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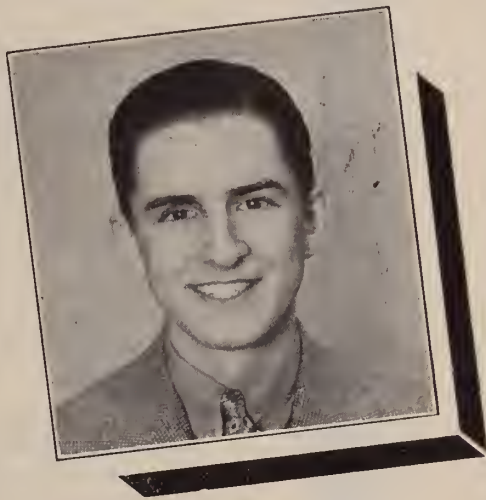
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(MINERAL PARTS PER MILLION)

Hypothetical Combinations	Geyser Water	Hathorn Water	Coesa Water
Ammon. chlorid	48.25	59.10	33.30
Lithium chlorid	21.07	64.49	46.43
Potass. chlorid	361.91	789.54	714.86
Sodium chlorid	2,010.48	8,594.84	4,233.14
Potass. bromid	9.23	160.00	13.90
Potass. iodid	1.10	4.80	1.36
Sodium sulphate	None	None	None
Sod. metaborate	Trace	None	Trace
Sodium nitrate	Trace	Trace	Trace
Sodium nitrite	Trace	Trace	Trace
Sodium bicarb.	2,213.78	424.71	1,331.15
Calcium bicarb.	1,829.14	3,380.84	2,519.74
Barium bicarb.	16.67	25.65	25.00
Strontium bicarb.	Trace	Trace	Trace
Ferrous bicarb.	9.94	40.07	5.86
Magnes. bicarb.	753.89	2,244.88	1,186.57
Alumina	7.14	4.98	6.37
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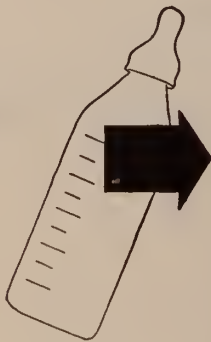
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1. Dornbush, A. C., Peterson, W. H., and Olson, F. R.: "The Carotene and Vitamin A Content of Market Milks." J.A.M.A., May 4, 1940, pp. 1748-1751.

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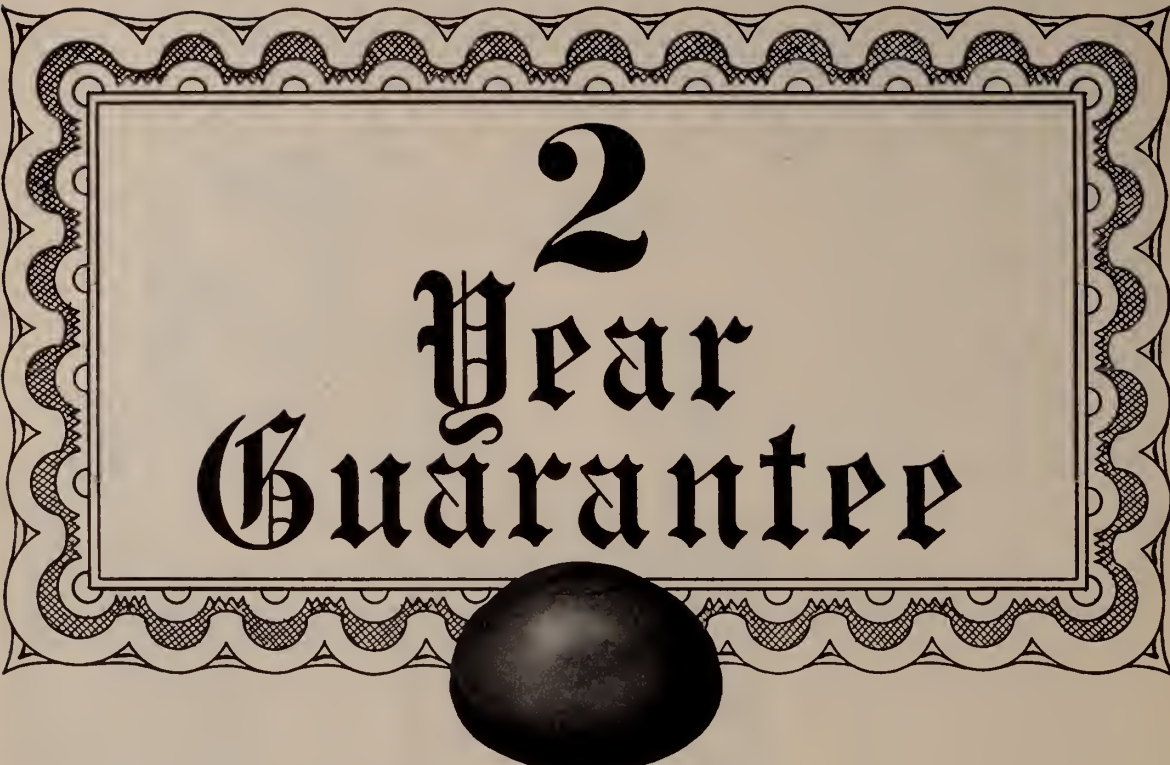
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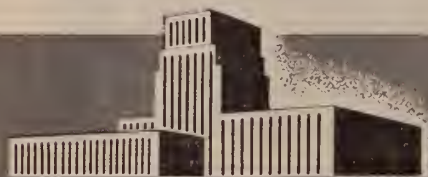
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*Arch. Otolaryng. 17:787, 1933



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ADVANCES IN CANNING TECHNOLOGY

I. Requirements for the Modern Canning Factory

● During the first decade of the 19th Century, Nicholas Appert, an obscure French confectioner, worked out empirically the basic principles of canning. In 1811, the first English edition of his book on the "Art of Preserving" was published (1). This text lays down the fundamentals of the canning process; it describes the necessary organization of a canning establishment and its equipment; and it lists canning procedures for more than 50 foods of both animal and plant origin.

Viewed in the light of modern knowledge, Appert's book is surprisingly complete and many of his observations amazingly accurate. Naturally, in the 130 years since his book was published, many advances have been made in canning technology. Consequently, when Appert's quaintly worded descriptions of the requirements for the use of his process are compared with those of modern commercial practice, some insight may be had as to the vast improvements which have been wrought in this important field of food preservation since its humble beginning.

One striking contrast between the old and new in canning lies in Appert's description of the necessary features of a canning establishment of his day. Appert's establishment apparently was composed of seven rooms or "apartments". Four of these were equipped to handle the preparation of fruits, vegetables, and foods of animal origin; the fifth room was devoted to the cleaning and storage of the glass bottles used as containers; the sixth room was the "sealing" room in which the bottles were corked after filling with food; the last room contained the large covered kettle in which the sealed containers were processed in boiling water.

The requirements for the modern cannery are, of course, much more exacting, both

from the standpoint of factory site, arrangement, and equipment. Today, canneries must be located close to the fields, orchards, or waters from which the raw materials are harvested. Rapid handling of freshly harvested raw stock—a prime requisite for quality of the final product—is thus facilitated. The factory site must also be chosen so that an adequate supply of potable water is available. The modern canning plant is arranged specifically for handling the product or products that will be canned. This provides for continuous, rapid, and even flow through the various operations comprising the canning procedure for the particular product.

Needless to state, the equipment requirements of the modern canning factory are also much more complex than in the days of Appert. Present-day, large-volume production—necessary for the manufacture of a low-cost product—requires the use of high-speed automatic equipment for conveying the raw materials through the cleansing, preparatory, and all other operations of the commercial canning procedure. Frequently, much of this equipment must be constructed of special metals or alloys; in all cases it must be so constructed as to permit rapid, thorough, periodic cleansing. To maintain and control this highly specialized machinery, a skilled mechanical staff is necessary.

Space will not permit fuller description of other requirements for the cannery of today. Thousands of such factories combine to form the American canning industry, whose products already have become so essential in our modern civilization and in our national defense. Commercially canned foods have fulfilled every prediction of Appert by whose "extensive practice and long perseverance" a new means of food preservation was made possible.

AMERICAN CAN COMPANY

230 Park Avenue, New York, N. Y.

REFERENCES

- (1). The Art of Preserving All Kinds of Animal and Vegetable Substances, M. Appert, Black, Parry, and Kingsbury, London, 1811.

We want to make this series valuable to you, so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned-foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles. This is the sixty-seventh in a series which summarizes, for your convenience, the conclusions about canned foods reached by authorities in nutritional research.



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EDITORIAL

Post-Graduate Opportunities

How often since your graduation from Medical School have you wished you could take a post-graduate course? and how often has that wish been deferred to a time when it might better be afforded?

We all do a certain amount of reading in order to keep in step with the modern trends in medicine; but how many of the doctors outside of the larger medical centers have the opportunity of brushing up in laboratory technique, or bedside diagnosis and treatment?

As we enter upon the second semester of the State Society, we all might take an account of stock, and ask ourselves two questions:

1. Have I availed myself of the opportunity for refresher courses provided by the Post-Graduate Education Committee of The Medical Society of New Jersey?

2. Can I afford to miss an opportunity which entails little expense and inconvenience?

If you are not enrolled in one of these courses, you are neglecting a fine chance to obtain ideal instruction, for the cost is very little in comparison to that charged by the average teaching institution; and these courses are given by instructors who specialize in their own particular fields of medicine or surgery.

It has been found that there is ample clinical material at hand in the larger hospitals which can be used to good advantage by the various instructors. Ward rounds have been made available in the Essex County institutions, especially in the study of tuberculosis, mental disorders, and contagious diseases.

Special courses were held this Fall in the modern treatment of peripheral vascular diseases, and physio-therapy. This coming Spring, courses will be available in amputations, fractures, and digestive diseases. All of these afford a real opportunity to obtain practical instruction in these particular fields.

Other activities which the committee has provided are post-graduate courses of lectures given by instructors outside the State. These have been under the Extension Division of Rutgers University.

The members of the committee have given much time and thought to these courses, and are desirous of extending their scope of function. They will help you to avail yourself of instruction outside the State, if you so desire.

WATSON B. MORRIS, M.D.,
President.

The Improvement of Medical Services

There are many people in this country who, seeing grave social defects that undeniably exist, feel that they must be remedied at once, and can see no other agency but the State to do it. Governments have made many attempts to do such things, but I doubt if there is in all history any instance of government correcting by direct action any social evil, except at a cost,—direct, or indirect, or both,—much greater than the original evil itself. Governments seldom look far enough ahead, or consider secondary effects, being solely concerned with the immediate problem.

I know no medical man who believes or says that the kind of service now rendered by physicians is the best that can be given. Undoubtedly the *distribution* of medical care to all the people is far from satisfactory, especially in some parts of the country. But efforts to improve that distribution are being made earnestly, widely, and in the main, intelligently, by the medical profession and by unofficial social agencies, both of whom are subjected to the spur and lash of external criticism. But the scientific method of experimental study of differing needs and conditions is more likely to produce permanent benefit and minimal injury, than the "artistic" governmental method of happy inspiration, and a handsome appropriation.

I am in entire accord with the requirement that organized medicine be honest about its de-

mands; and I propose to urge increasingly, to the extent of my influence, that its members give thoughtful consideration to the basic principles on which they rest their position and arguments.

I agree also that organized medicine is trying to save the status, economic and otherwise, of its members. To do this is both its right and its duty if it feels, as I do, that their secure status is for the best interests of the public as well as for their private benefit. But I deny that organized medicine is trying to increase the financial burdens and political employees and dependants, for I know positively that it is resisting these very things.

We know that all the wisdom of the profession does not rest in any single group of practicing physicians. If a survey were taken of what many state and county societies from coast to coast are attempting, a much better idea would be had of the possibilities of American medicine than can be gotten from the philosophical opinions of critical pressure groups. Physicians constitute the only group that can determine the existing defects, and are able to make the corrections needed to provide an adequate supply and distribution of medical service of a quality and type which will best meet the needs of the public.

ELIAS J. MARSH, *Vice-President*,
The Medical Society of New Jersey.

Conflict vs. Co-operation

Too much control by laymen is the complaint frequently made about the present status of health education and health administration. Doctors often resent the lay leadership of public health activities, health propaganda, and hygienic education in many New Jersey communities.

The Administration of your Medical Society feels that the answer to this problem is *more interest in public health activities by the doctors themselves*. In line with that approach, the Society took part in the Annual Meeting

of the Health and Sanitary Association in Asbury Park, November 15-16, 1940. Dr. Morris, President of The Medical Society of New Jersey, was a speaker at the meeting; and your Mental Hygiene Committee sponsored a special program on "Mental Hygiene and Public Health" under the chairmanship of Dr. Joseph Raycroft. One of the speakers was Dr. J. L. Pessel, of the Mental Hygiene Committee of The Medical Society of New Jersey. Other members of the Medical Society who took part in the program were Dr. L. D. Bristol, Dr.

Walter G. Alexander, Dr. D. O. Hamblin, Dr. Ellen Potter, Dr. Joseph Kler, Dr. Daniel Bergsma, Dr. Charles Craster, and Dr. LeRoy Wilkes.

The Public Relations Committee was represented by its Chairman and Secretary, Dr. Robbins and Dr. Davidson, respectively, who set up and serviced an exhibit on the structure and function of the State Medical Society.

This project represents a serious effort at working with affiliated groups. In a similar way your Society has sought to coöperate with the New Jersey Welfare Council by supplying Dr. Wilkes as a member of the Board, Dr. Davidson as a discussion leader, and Dr. Snedecor as a speaker. Dr. Morris has been active in addressing associations of pharmacists, den-

tists and members of allied professions. It must be clear by now that the day is past when our profession can secure public goodwill by remaining isolated and aloof from contacts with allied groups. All members of the Society should keep open their channels of communication to associated professions. If it ever appears that any non-medical group is too articulate or too active in the prosecution of a medical project, the sound approach is to work *with* that group rather than to work *against* it.

The Asbury Park meeting of the Health and Sanitary Association was a living demonstration of the good-will effect of such coöperation.

CHARLES M. ROBBINS, M.D., Chairman,
Public Relations Committee.

Eye-Sight Tests

Doctors visiting public schools daily and examining pupils should educate the educators in the essentials of eyesight conservation, and some of the indications for its intensive study by the family physician. This important portal of learning must be kept open. School physicians can point out some of the conditions which are missed when the Snellen Chart is the only test that is applied.

The Snellen Chart Test picks out only the near-sighted children, and therefore has a limited degree of usefulness. The far-sighted child, however, reads the letters on the chart easily, and is passed as normal; yet when he begins to learn to read, he may find it difficult to focus on near work, and may become fatigued and discouraged over the attempt to read and write. The child with astigmatism may have a similar experience.

Another defect which may be missed by the Snellen Chart Test is that known as "fusion-

difficulty". Fusion-difficulties arise when the eyes fail to accommodate themselves either to near or far objects by turning toward each other to look at a very near object, or to look straight ahead along parallel lines to look at far ones. When this difficulty is obvious, it is known as "strabismus". These fusion difficulties are not detected by the Snellen Chart Tests, unless the vision of one eye has become impaired.

Symptoms indicating the need of eye tests are nervousness, fatigue, blinking of the eyes, frequent styes, redness of the eyes or lids, holding the book or paper at an unusual angle or too near or too far (about fourteen inches is the normal distance), headaches, car sickness, or other unexplained nausea, inattention, frowning, worried expression. In fact, any difficulty in learning to read should be considered a possible symptom of defective vision.

L. A. W.

Medical Service Administration was launched January 1, 1941. Will you become a participating physician?

ORIGINAL ARTICLES

SILICOSIS

By BERTHOLD S. POLLAK, M.D., F.A.C.P., Medical Director; and SAMUEL COHEN, M.D., Senior Resident Physician, Hudson County Tuberculosis Hospital, Jersey City, N. J.

Read before the Staff Meeting of the Jersey City Medical Center, February 8, 1940.

I. THE PROBLEM

Silicosis is commanding the increasing interest of physicians and legislators as one of the biggest problems in industrial medicine. Also cases of silicosis are encountered frequently enough in the clinics and medical wards of large hospitals in a metropolitan community to warrant the focussing of medical attention on the disease. Silicosis is of front-rank importance for several reasons:

A. Because it is so incapacitating and widespread. It has been estimated that at least 1,200,000 men in this country are engaged in occupations which expose them to the harmful effects of silica dust inhalation.

B. Because it increases susceptibility to pulmonary infection in general, and to tuberculosis in particular. Some reports have indicated that as high as 75 per cent of silicosis patients die of a complicating tuberculous lesion.

C. Because there is no known cure for silicosis today; absolute prevention seems to be the solution, but it is not yet attainable.

D. Because adequate legislation should be enacted to make silicosis a properly compensable disease.

II. DEFINITION OF SILICOSIS

Pneumoconiosis is the general term used to embrace all pulmonary diseases resulting from the inhalation of inorganic dusts. The most familiar and most common affection of the group is anthracosis (coal-dust inhalation). Silicosis is next in frequency, but by far the most significant. It has been defined as a non-infectious disease produced by the inhalation

of microscopic particles of free silica (SiO_2), characterized clinically by dyspnoea, pathologically by fibrosis, and roentgenologically by definite changes.

Limited space will not permit discussion of silicatosis, better known as asbestosis.

Some of the more well-known occupations in which silicosis develops are rock drilling, coal mining, sandblasting, foundry work, granite cutting, and the manufacture of abrasive soaps. Occupational aspects of the medical history should be elicited, for silicosis may manifest itself several years after exposure to silica has ceased.

III. ETIOLOGICAL FACTORS IN SILICOSIS

What is the prospect of a man exposed to free silica dust in any of the above-mentioned occupations,—for example, in acquiring silicosis? There are several important factors to be considered.

A. *The character and composition of the dust* to which the employee is exposed. A necessary procedure to evaluate the risk is to determine the percentage of total silica (free and combined forms) in the working atmosphere. Silicosis can develop by inhaling, for a sufficient period, dust which contains at least 30 per cent silica.

B. *The amount of dust inhaled*: The greater the dosage, the greater is the hazard. The concentration of dust particles, expressed in millions per cubic foot of air, can be counted by a special technic.

C. *Size of dust particles*. It is the unanimous opinion that the greatest harm is done by silica particles between one and three micra

in diameter. Particles of this size (which is the usual size of bacteria) can more easily elude the defensive mechanism of the upper respiratory tract, and thus gain access to the alveoli of the lung.

D. *Duration of exposure*: It is obvious that the previously mentioned factors bear a direct relationship to the exposure period required to produce silicosis. Cases of acute silicosis have been described which became manifest within two years after exposure. In the vast majority of instances, the disease develops insidiously and most frequently over a period of many years.

E. *The effect of other substances inhaled simultaneously with the dust that contains silica*: Associated organic dust may produce allergic manifestations, but not fibrosis of the lungs; and silicosis is first and foremost a form of pulmonary fibrosis. The presence of alkalis in finely powdered form, as in the process of abrasive soap-making, increases the rapidity of the action of silica in the pulmonary tissue, according to some observers, because silica is more soluble in alkaline solution. Recently there have been a few reports concerning the inhibitory action of added dusts, particularly aluminum. Research work in seeking other dusts which may minimize the chemical action of silica dust would appear to be one of the possible fruitful methods in the prevention of silicosis.

F. *The resistance of the individual*: It is very probable that individual susceptibility to silicosis is increased by chronic sinus infection which lowers the efficiency of the upper respiratory mechanism; and by pulmonary affections, such as pneumonia, pleurisy, emphysema, and bronchiectasis, which decrease vital capacity and may seriously interfere with adequate lymphatic and bronchial drainage of the inhaled siliceous dust.

G. The extent to which *mechanical devices* are utilized to remove silica dust from the workers' environment.

IV. THE EFFECT OF SILICA ON THE LUNGS

A. Much work has been done to demonstrate the cause of the harmfulness of silica. Early investigators attributed it to the mechanical irritation of the dust particles on the

pulmonary parenchyma due to their hardness, sharpness, and angulation. The consensus of opinion today is, that silica in colloidal form is a cell poison, and exerts a toxic action upon the tissues which leads to proliferation of connective tissue. The chemical agent is silicic acid.

B. *Pathological Changes in Silicosis*: The most important feature is the formation of connective tissue.

The silica particles which escape the protective mechanism of the upper air passages are ingested by the phagocytes in the bronchioles or alveoli, and traverse the familiar pathway by way of the lymphatics to the lymph nodes at the hilum. The phagocytes also accumulate in and about the intrapulmonary lymphoid tissue; and with prolonged exposure, also in the lymph nodules located at the junction of the deep and superficial sets of lymphatics just beneath the pleura. In the clusters of phagocytes, fibrous tissue makes its appearance in spherical layers or whorls, producing the characteristic silicotic nodule. These nodules increase in size, and become confluent; and in so doing still further add to the obstruction of the flow of lymph. *Emphysema* is an almost invariably associated finding.

Grossly, the lungs are indurated, and on section show pigmented nodules of varying size and density which in advanced cases form large masses. These are usually most numerous in the mid-lung regions. The intervening pulmonary tissue has, in many cases, a diffuse, finely honeycombed appearance due to emphysema; and blebs and bullae may also be present.

Interestingly enough, bronchiectasis, in the uncomplicated case, is uncommon. The pleura may be thickened, particularly in the late stage, and the tracheo-bronchial lymph nodes are enlarged.

C. *Silica Content of Lungs*: Attempts have been made to correlate the silica content of lungs with the extent of pulmonary fibrosis. When the percentage of free and combined silica is greater than 1.6 per cent of the total dried lung tissue, the fibrosis itself is sufficient to produce marked respiratory decompensation and death. Quantities less than 1.0 per cent seldom cause death in uncomplicated silicosis.

V. CLINICAL AND X-RAY FINDINGS IN SILICOSIS

The diagnosis of silicosis is based primarily upon a history of exposure to silica dust, and the roentgenographic examination. For purpose of description, the disease has been rather arbitrarily divided into three stages. However, there is no absolute line of cleavage between these phases, and overlapping occurs.

A. *First Stage*: The individual may have no complaints, or perhaps slight cough and slight dyspnoea on exertion. Physical examination of the chest is essentially negative.

The roentgenogram of the chest shows a more or less generalized increase in linear markings, with some beading along the trunk shadows, particularly in the hilar zone. The findings indicate a mild degree of fibrosis, but there is nothing pathognomonic at this time for silicosis. Chronic passive pulmonary congestion, asthma, chronic bronchitis, and emphysema may give a very similar x-ray appearance.

B. *Second Stage*: Dyspnoea and cough are usually increased; and the physical signs are those elicited over an emphysematous chest. The radiograph, which now becomes characteristic of silicosis, reveals the dissemination of miliary or medium-sized, slightly irregularly shaped dense nodules in both lung fields, but usually more concentrated in the middle third. Most of the nodules are discrete, although confluence may be seen in some areas. The hilar shadows are widened due to enlarged bronchopulmonary nodes.

The silicotic nodules may be simulated roentgenographically by:

- a. Blood vessels seen end on.
- b. Hematogenous or bronchogenic nodular tuberculosis.
- c. Bronchopneumonia.
- d. Diffuse pulmonary carcinomatosis.

Third Stage: Dyspnoea often is quite marked even on little exertion, and the individual's capacity for physical work is seriously impaired. The x-ray film shows evidence of increased mottling; the nodules are larger, and become more conglomerate; and large, dense shadows are seen representing massive areas of fibrosis. The explanation of the dyspnoea in silicosis has been attributed by Cole and Cole to:

1. Nodule formation.
2. Dense alveolar consolidation.
3. Capillary obstruction and dilatation.
4. Emphysema.

VI. PROGNOSIS

Silicosis is a serious disease. The prognosis depends to some extent on whether the individual has a simple silicosis, or silicosis complicated particularly by pulmonary infection.

A. *Simple Silicosis*: The majority view is that the disease progresses in many instances, even though the individual is removed from exposure, and this constitutes one of the most crucial aspects of the whole silicosis problem. It has been stated that it is not so much what the condition of the silicotic is *today*, as to what it will become *tomorrow*. According to observations made by Bohme-Bochum, silicosis progressed after removal from exposure in 20 per cent of the cases in stage I, in 40 per cent in stage II, and in practically all cases in stage III.

B. *Silicosis and Infection*: The most common superimposed pulmonary infection in silicotics is *tuberculosis*. From studies based on the findings of 1,271 autopsies done at the White Haven Sanatorium in Pennsylvania, which admits many miners, it was found that pulmonary tuberculosis was twice as common in silicotic patients as in male adults without silicosis. According to Gardner, of Saranac Lake, 75 per cent of patients with silicosis die of tuberculosis. In 1934 the United States Public Health Service found that 20 per cent of the regular miners, and 57 per cent of the rock drillers in hard coal mines in Pennsylvania over the age of fifty-five years showed clinical evidence of pulmonary tuberculosis. Tuberculosis among silicotics is more prevalent in the middle age group than among young adults, which is just the reverse of its incidence in the general population; the reason being that the older miners have had longer exposure to siliceous dust, a greater opportunity for development of silicosis, and subsequently of tuberculosis.

The tuberculous lesions complicating silicosis are frequently of a productive type. It has also been noted in many cases that the dissem-

ination of tuberculosis is slower and less extensive than in simple tuberculosis, apparently due to the massive fibrous tissue which "traps" the tubercle bacilli,—and this decreases the opportunities for spread through the intracanalicular channels or to other organs by way of the vascular system.

VII. DIAGNOSIS

The ante-mortem diagnosis of tuberculosis in silicotics is quite often a difficult matter, especially from a roentgen point of view. Silicosis, as noted, produces a multiplicity of shadows, and recognition of superimposed tuberculosis may be entirely obscured, except in cases where cavitation is obvious.

X-Ray Picture: Some observers have called attention to changes in the x-ray appearance of preëxisting silicotic lesions to suggest concomitant tuberculosis—namely, an increase in size of the lesions and loss of their sharp outlines. However, these are far from infallible criteria.

Laminography: We believe it likely that laminography (or taking serial "sections" of the lungs for roentgen study) may help for increased visualization of the presence and distribution of nodule formation in silicosis; and to demonstrate or better delineate cavity undiagnosed or only suspected on the ordinary x-ray film.

Sputum Study: However, radiology must often give precedence to the clinical examination and bacteriological study of the sputum. The presence of fever, loss of weight, hemoptysis, or moist râles, are very suggestive findings of added tuberculosis.

As far as the sputum is concerned, repeated cultures and guinea pig inoculations may sometimes be necessary to demonstrate tubercle bacilli.

A pertinent question arises at this time as to *why silicotics should develop tuberculosis* so frequently. There are some interesting clues. Silica is soluble in tissue fluids, and makes a good pabulum for tubercle bacilli to thrive on. It is known, for example, that the addition of silica to a culture medium enhances the growth of the organisms. Kettle, an English investigator, showed that if bovine tubercle bacilli

are injected intravenously in white mice, the organisms will localize predominantly and multiply in those areas where silica had been injected subcutaneously. Gardner has shown that systemic tuberculosis will develop rapidly and produce death in animals which have been exposed to silica and which have subsequently been inoculated with tubercle bacilli; and that in animals not previously exposed to silica, the dissemination is not nearly so widespread. While the analogy is not entirely correct, it seems that silica may be considered in the manner of a *catalytic agent* in the reaction between the host and tubercle bacilli.

Other Complications: Pulmonary complications, other than tuberculosis, also occur more frequently than in normal individuals—such as chronic bronchitis, pneumonia, and spontaneous pneumothorax (due to rupture of emphysematous blebs). Chronic irritation has been considered one of the possible factors in the causation of cancer. Bronchial carcinoma, however from most reports, is no more common among silicotics than in the general population.

Heart Disease: A word as to silicosis complicated by heart disease—referring again to the autopsy material examined at the White Haven Sanatorium, it was noted that 23.3 per cent of the miners died of heart disease, in contrast to 13.5 per cent among the non-miners. Myocardial failure of the right heart was most common and believed to be due to hypertension of the lesser circulation as a result of diffuse emphysema, fibrosis, and pulmonary arteriosclerosis.

VIII. TREATMENT

Fibrosis of the lungs produced by silicosis is an irreversible pathological change. There is no known therapy which will dissolve the nodules of fibrous tissue. To remove the patient from the dust exposure and to treat him symptomatically is the most that can be done in many cases. An abdominal binder, which keeps the diaphragm in the expiratory position, may be helpful in some cases of dyspnoea. In silico-tuberculosis, collapse therapy measures like pneumothorax, etc., are not applicable, as a rule, because of a bilateral lesion and poor respiratory reserve. However, it is essential

that segregation of infectious cases in a sanatorium should be rigorously enforced.

The important phase of treatment to be emphasized consists in *prevention* of dust formation and elimination of sources of infection.

Prevention of Silicosis: This may be divided into two main aspects—medical and mechanical.

A. *Medical.*—The first urgent step is pre-employment examination of prospective workers to eliminate the physically unfit.

The examination should include: (1) a thorough history, personal and occupational; (2) a competent physical examination to detect particularly infected tonsils, chronic sinusitis; and (3) an x-ray film of the chest to pick up pulmonary disease. This film is of value also as a basis for comparison with future roentgenograms from both medical and medico-legal points of view.

Follow-up examinations at least once annually, including a chest plate, should be done.

B. *Engineering or Mechanical Control.*—This is of paramount importance.

Methods should be adopted, if possible, to eliminate the harmful siliceous dust from the working atmosphere by suitable ventilation and engineering devices; and to encourage the use by the employee of mechanical protective equipment which should not be too cumbersome.

Medico-Legal Aspects.—It is not our purpose to enter into the controversial medico-legal aspects of silicosis. Suffice it to say that a number of suggestions were proposed by the National Silicosis Conference in 1938 which received favorable attention. These suggestions embody a program which sets up the essential machinery for the determination of disability and compensation in silicosis.

IX. CASE REPORTS

We wish to supplement this brief review of some of the salient features of silicosis by short clinical excerpts and roentgen films of cases of silicosis which showed in addition some of the complications mentioned above.

CASE I

J. H., aged 44, worked in the anthracite coal mines of Pennsylvania for the greater period between 1927-1935. He entered the hospital April 6,

1937, because of dyspnoea of two weeks' duration. The first roentgenogram (April 7, 1937) (Fig. 1) showed evidence of a right-sided spontaneous pneu-

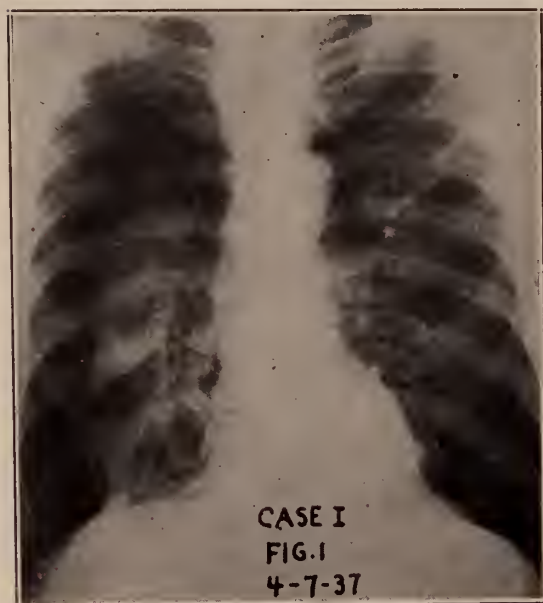


Fig. 1—Case one, April 7, 1937

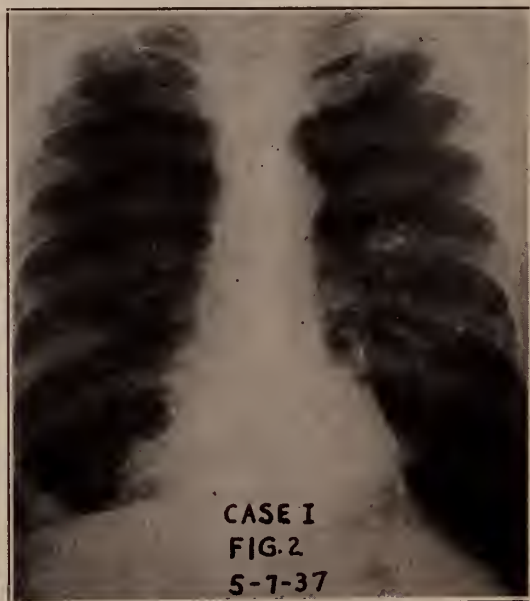


Fig. 2—Case one, May 7, 1937

mothorax; also some increase in broncho-vascular markings and linear fibrosis, particularly in both hila regions and extending downward from the right hilum. The tuberculin test was negative to 1.0 mgm. of old tuberculin, and several sputa examinations were negative for tubercle bacilli. Air was removed on one occasion from the pleural cavity for relief

of dyspnoea, and spontaneous resorption occurred rather rapidly.

The next chest x-ray film (May 7, 1937) (Fig. 2) showed a residual pleural haziness at the right base. The case was considered as one of first stage silicosis with a superimposed spontaneous pneumothorax attributable most likely to rupture of an emphysematous bleb.

CASE II

L. B., aged 47, was admitted January 16, 1935. The patient worked in a foundry from 1916-1931, but after that date had very irregular employment at odd jobs. Cough was present since 1928; and at the time of admission, expectoration amounted to one ounce daily of muco-purulent sputum which was negative for tubercle bacilli. He was thin and chronically ill appearing.

The roentgenogram (January 18, 1935) (Fig. 3) showed the left lung to be riddled by dense, slightly irregular nodules which tended to become confluent in the middle third of the lung field; similar lesions were noted in the upper portion of the right lung, the remainder being obscured by a homogeneous density indicative of a pleural effusion. Yellow serous fluid was aspirated. The tuberculin test was positive. The final diagnosis was that of second-stage silicosis, complicated by a tuberculous pleurisy. The patient died November, 1935.



Fig. 3—Case two, January 18, 1935

CASE III

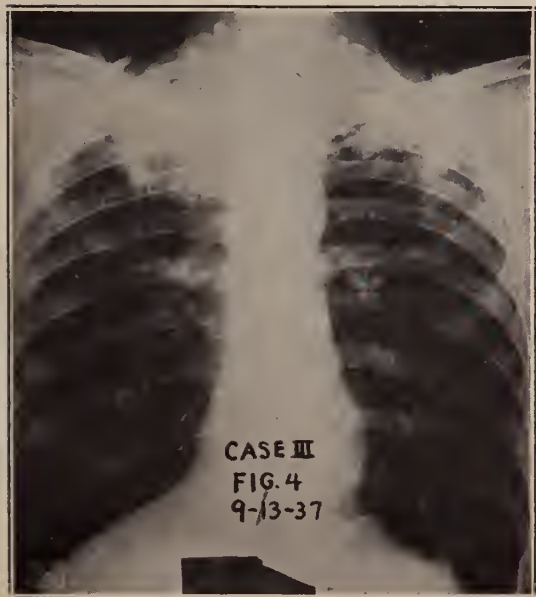


Fig. 4—Case three, September 13, 1937

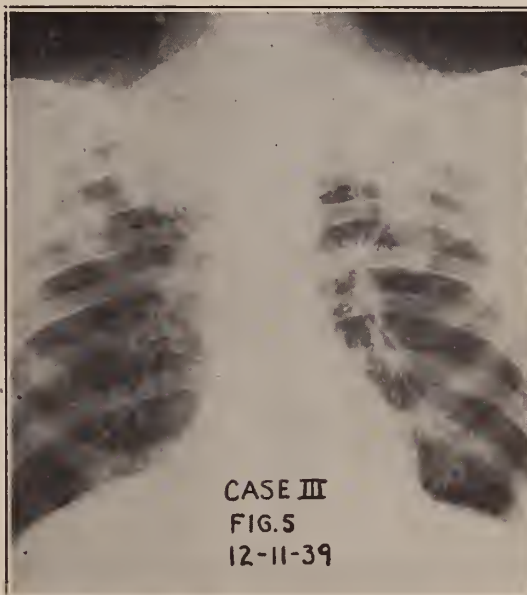


Fig. 5—Case three, December 11, 1939

F. H., aged 64, entered the Tuberculosis Hospital December 1, 1938. Between the years 1900-1931, the patient was a foundry worker but not employed since then. His chief complaints were dyspnoea, cough, and thoracic pain, dating from about December, 1936.

A chest plate taken September 15, 1937 (Fig. 4), while he was attending the clinic revealed bilateral fine nodular lesions particularly in the upper halves of both lungs, with larger areas of dense infiltra-

tion in the first and second anterior interspaces on either side.

The film taken December 11, 1939 (Fig. 5), showed a definite increase in the dense lesions.

While comparison of the radiographs strongly suggest the presence of associated tuberculosis, this as yet has not been proven. More than twenty concentrated sputum examinations have been negative for tubercle bacilli to date. The present impression of the case is that of third-stage silicosis, with possible pulmonary tuberculosis.

CASE IV

H. D., aged 57, was admitted March 4, 1937. Prior to his arrival in this country in 1912 the patient was a farmer in Poland. For the ten-year period ending 1926 he worked in the hard coal mines of Pennsylvania; and from 1926 up until six months before admission he did various types of work in factories and on farms. In 1934 he developed dyspnoea; in 1936 cough and expectoration appeared, and he had lost thirty-six pounds in the last half year.

Chest.—Emphysematous in type.

Right Lung.—Dullness and amphoric breath sounds noted from apex to 6 v. s., with coarse râles throughout posteriorly; anteriorly râles were heard over the upper lobe.

Left Lung.—Diffusely scattered râles present.

The chest x-ray March 6, 1937 (Fig. 6), showed scattered patchy dense infiltration with confluence in some areas, and a cavity 3.0 cm. in diameter, overlying the second anterior rib on the right.

This film shows extremely well, increased densities in both hila areas due to enlarged nodes.

Patient's sputum was positive for tubercle bacilli. His clinical course was progressively unfavorable, and he died April 21, 1937. The final diagnosis was silico-tuberculosis.

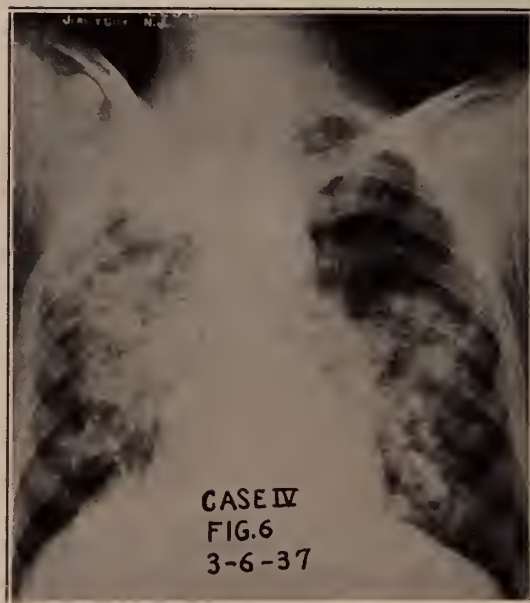


Fig. 6—Case four, March 6, 1937

CASE V

Z. P., aged 43, was admitted August 29, 1934. The patient was a caisson worker and subway rock driller from 1910-1915, and wore no protective device. Even while doing this work, he had a cough that became aggravated in 1933 at which time he also noted dyspnoea, weakness, and loss of weight.

The roentgenogram of August 30, 1934 (Fig. 7), showed bilateral diffusely scattered nodular and

confluent dense areas of infiltration, with definite large excavations in the first and second anterior interspaces on the right. The right diaphragm was irregular. Sputum was positive for tubercle bacilli. Note the marked progression of disease on the x-ray film of December 3, 1934 (Fig. 8). The admixture of silicosis and tuberculosis made roentgen differentiation of the two a very difficult matter in many areas. The patient died January, 1935.

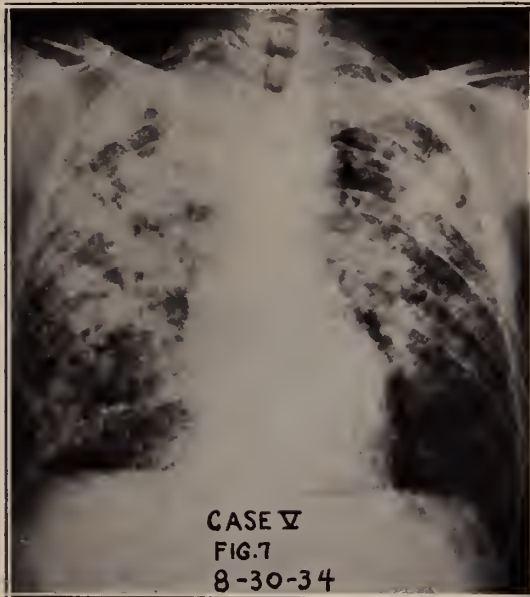


Fig. 7—Case five, August 30, 1934

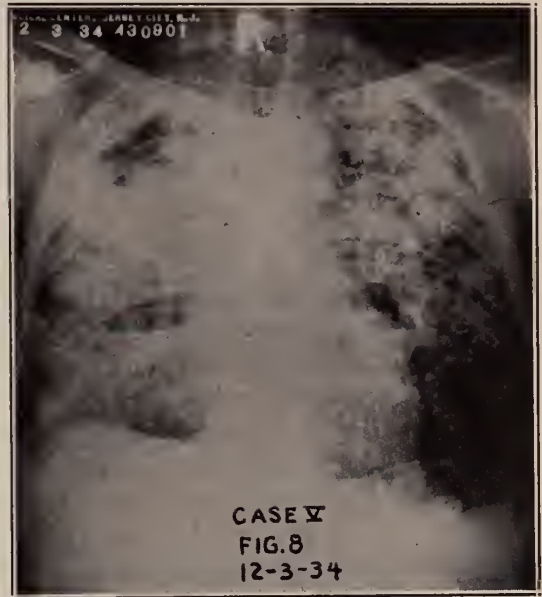


Fig. 8—Case five, December 3, 1934

UROLOGY IN GENERAL OFFICE PRACTICE

By MEREDITH F. CAMPBELL, M.D., New York

Professor of Urology, New York University College of Medicine

Presented before the Passaic County Medical Society, Paterson, New Jersey, October 24th, 1939.

Various surveys have indicated that the incidence of urologic problems in general practice varies from two to fourteen per cent. There is no doubt that the treatment of venereal disease is an important increment in the practice of many physicians, especially at the outset of their careers. Yet a surprising number feel that the treatment of venereal disease is beneath their dignity, and unworthy of their peculiar talents.

Many cases of serious urologic disease are overlooked because of failure diagnostically to consider possible urogenital tract pathology. For example, in advanced prostatic obstruction, and in long-standing urinary infections, more than half the patients present pronounced gastro-intestinal disturbances due to urinary toxemia, which is the late combined result of renal injury caused by urinary backpressure and the ravages of infection. In these cases, the gastro-intestinal disturbances are variously diagnosed and treated solely as gastritis, gastric ulcer, biliousness, intestinal indigestion, biliary tract disease, cholecystitis, and so forth. There is loss of weight, or in children, failure to gain, loss of appetite, anemia, and the usual chain of symptoms consequent to faulty alimentation. It is common observation that with eradication of the urinary obstruction or persistent infection, striking and prompt improvement in alimentation and appetite occurs, followed by gain in weight.

HEMATURIA

The potential significance of hematuria merits reconsideration. In Figure 1 are shown some of the commoner causes of hematuria. While most of these are well known to physicians in general, attention may wisely be directed to some of the unusual causes, notably the blood dyscrasias, and medicinal (e.g. Salol). Yet we are still seeing patients with advanced carcinoma of the bladder whose hematuria had been treated with sundry medi-

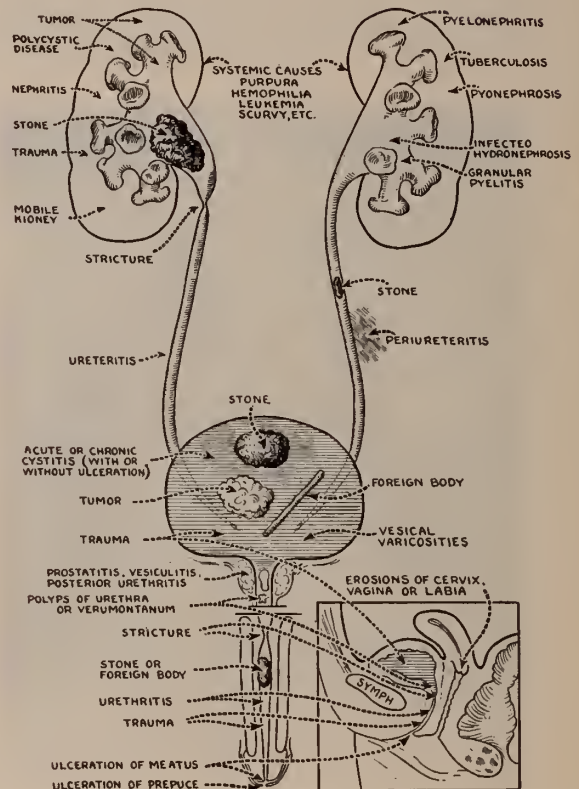


FIGURE 1.—Usual Causes of Hematuria

cal therapies for six months or longer, and to whom an early cystoscopic diagnosis and adequate treatment would have been life-saving.

Hematuria is always a grave danger signal, and its cause should be determined at once. In adults, hematuria most often means new growth, renal tuberculosis, stone, or nephritis; in children the order of significant incidence is nephritis, tumor, and renal tuberculosis.

PYURIA

Pus in the urine is an everyday observation of great clinical importance; the commoner causes of pyuria are indicated in Figure 2. Urinalysis is the keystone of the urologic diagnostic arch; and if it cannot be properly performed, conclusions are apt to be erroneous. Therefore the method of collection of the

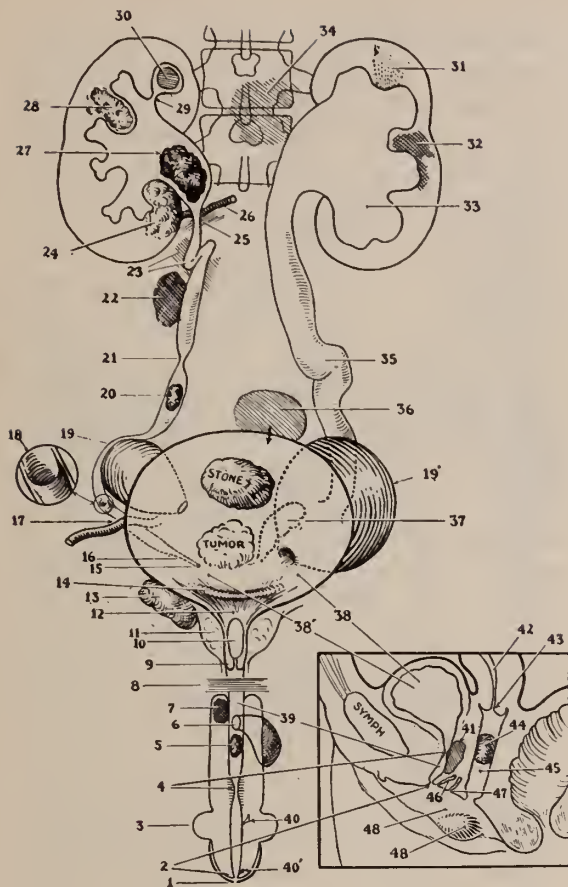


FIGURE 2.—Usual Direct or Indirect Causes of Pyuria

1. Stenosis of prepuce.
2. Stenosis of urethral meatus.
3. Paraphimosis.
4. Urethral stricture.
5. Urethral stone.
6. Urethral diverticulum.
7. Peri-urethritis; periurethral abscess.
8. Cowperitis; chronic external sphincterospasm.
9. Congenital valves of posterior urethra.
10. Hypertrophy of verumontanum; verumontanitis.
11. Prostatitis; prostatic abscess.
12. Contracted bladder neck; median bar.
13. Periprostatis or pelvic suppuration.
14. Mucosal fold at bladder outlet; trigonal curtain.
15. Stricture of ureteral meatus; ureterocele.
16. Ureterovesical junction stricture.
17. Vascular obstruction of lower ureter.
18. Congenital ureteral valves.
19. Ureteral obstruction by diverticulum compression.
- 19'. Diverticulum.
20. Ureteral stone.
21. Ureteral stricture.

22. Peri-ureteritis; peri-ureteral phlegmon or abscess.
23. Ureteral kink; peri-ureteral fibrous bands.
24. Renal tumor.
25. Uretero-pelvic junction stricture.
26. Aberrant vessel (obstruction of upper ureter).
27. Pelvic stone.
28. Renal tuberculosis.
29. Stricture of calyceal outlet.
30. Calyceal stone.
31. Pyelonephritis.
32. Pyonephrosis.
33. "Pyelitis"; infected hydronephrosis.
34. Perirenal suppuration invading urinary tract; spinal disease (Pott's, etc.).
35. Hydro-ureter.
36. Pericystic abscess rupturing into bladder.
37. Seminal vesiculitis.
38. Neuromuscular vesical disease.
- 38'. Cystitis.
39. Urethritis.
40. Folliculitis (Littre).
- 40'. Folliculitis (Morgagni).
41. Peri-urethritis; peri-urethral abscess.
42. Endometritis.
43. Cervicitis.
44. Foreign body in vagina.
45. Vaginitis.
46. Skenitis.
47. Folliculitis of introitus.
48. Bartholinitis.

pyuric specimen for microscopic and bacteriologic investigation is of prime consideration.

Specimen from a Female.—In the female, a voided specimen is scarcely worth examining except for specific gravity and sugar. Females of all ages should be catheterized if the collected specimen is to be examined bacteriologically, or for pus. A small, soft rubber catheter is used, and this demands introduction under visualization. The parts should be well cleansed first and the first few cubic centimeters allowed to run out before specimen collection is begun.

To repeat: soft rubber catheterization under visualization should cause no trauma, not even to the newborn. A tender age is no contraindication to catheterization if due gentleness is observed.

Specimen from a Male.—In males a satisfactory specimen can usually be obtained by the following method:

1. Have the patient retract the prepuce freely.

2. Wash the glans and meatus well with an antiseptic solution such as bichloride of mercury, or oxycyanide of mercury, 1:500.

3. Have the patient pass a few cubic centimeters of urine.

4. Collect the specimen proper in a sterile receptacle.

5. *Catheterization*.—Unless these conditions can be met in the male, he too should be catheterized when pyuria and infection exist or are suspected.

Microscopic Examination.—It makes no difference whether pus cells in the urine are clumped or single. The demonstration of more than two or three pus cells in a low-power field of an uncentrifuged specimen demands further investigation. Unless hemocytometric or equivalent counts of uncentrifuged fresh urine specimens are insisted upon, we have no common basis for comparison on cell count estimation. Unfortunately, microscopic urinalytic reports from most laboratories are wholly unreliable. Primarily, these are from errors consequent to the method of urine specimen collection; I question that one in 500 specimens is collected by catheterization.

"Pus" Cells.—A second grave, yet almost routine, error is the designation of various forms of epithelial cells as pus cells. No cell should be called a pus cell unless it contains the polymorphic nucleus, which we commonly designate as the "pawnbroker's" nucleus. If it cannot be demonstrated, the cell is not a pus cell.

Pain or masses along the course of the urogenital tract, disturbances of urination, and persistent acute urinary infection, also demand urologic investigation. These manifestations require a careful urinalysis, and at least an excretory (intravenous) urographic study; the urographic interpretation should be delegated to an urologist or a competent roentgenologist. Unfortunately, there are still comparatively few roentgenologists capable of first-grade urographic interpretation. In the excretory urographic series, failure of the kidney to excrete on one side must be considered to indicate renal damage until proved otherwise. It is true that occasionally we find a kidney which temporarily fails to excrete an intravenously

injected urographic media, but which on ureteral catheterization and dye-test renal function studies, is found to be sound. For this reason, nephrectomy should rarely be performed on the basis of excretory urographic data alone. With suggestive abnormality in the excretory urographic findings, a thorough urological investigation should follow.

CONDITIONS SUITABLE FOR OFFICE TREATMENT

The extent to which the practitioner may justifiably attack urologic diseases in the office will depend largely upon his training, knowledge, ability, equipment, and nerve. Many procedures for which we formerly sent the patients to the hospital can now be carried out in the office. With the aid of excretory urography, self-administered nitrous-oxide oxygen analgesia, and other innovations, we are now able to carry out 90 per cent of our diagnostic investigations in the office. Nor is this unusual among urologists in the United States today. Yet we may justifiably pass over this phase of urologic practice, since it is unlikely that men not specializing in urology will be widely concerned with its more complicated problems. Rather, we will discuss here briefly urologic conditions which are commonly encountered in the office of the physicians in general practice, the majority of which conditions can be adequately managed outside the hospital.

PHIMOSIS

Phimosis is one of the commonest congenital lesions. At birth most prepuces are long and relatively tight; but if the mother will daily retract the long prepuce well behind the glans, the foreskin will usually become adequately spacious and mobile, and will not harbor smegmatic debris. In many instances, the tight preputial orifice can be satisfactorily dilated with a hemostat, and circumcision averted (Figure 3). Occasionally the long prepuce is extremely tight at the opening, even to the degree of causing urinary obstruction. Here liberal dorsal split or circumcision is indicated. Doubtless obstetricians are performing circumcision unnecessarily in many new-born boys, but this is more desirable than failure to relieve important phimosis in the few. Excepting ritual-

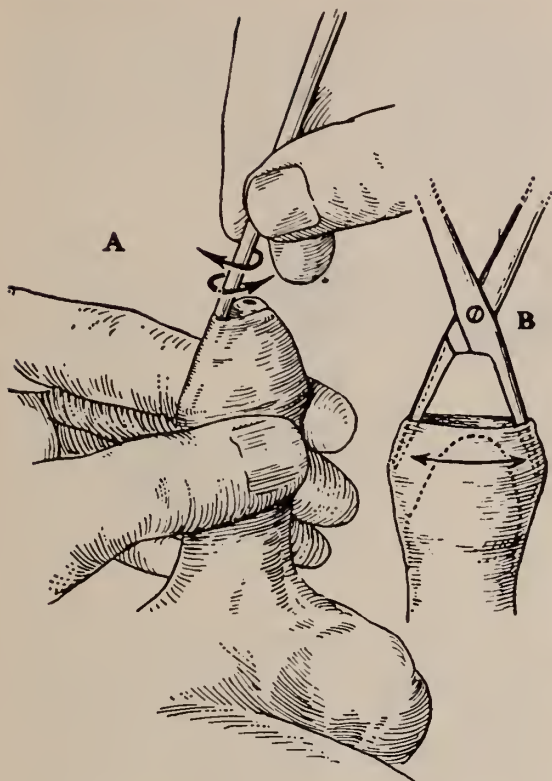


FIGURE 3.—Treatment of Phimosis and Adherent Prepuce

- A. Encircling prepuce with probe.
- B. Stretching prepuce with hemostat.

istic considerations, the indications for circumcision are:

1. Hygienic reasons.
2. The relief of urinary stasis.
3. To eradicate chronic balanitis, or for paraphimosis.

It is recognized by students of cancer that carcinoma of the penis rarely occurs in properly circumcized individuals. This is especially striking among Jews and Mohammedans. Moreover, by the retention of smegmatic debris beneath the tight prepuce, smegmatic stone or stone composed of urinary salts, may form in the post-coronal sulcus. Also, with the retention of fermenting urine beneath the prepuce, secondary ulceration of the mucosa occurs. As a rule, circumcision in boys is best performed in the hospital under general anesthesia; most circumcisions I do are in adults, in the office, and under local anesthesia.

Paraphimosis results from interference with the preputial vascular return consequent to leaving a tight prepuce retracted behind the penile corona.

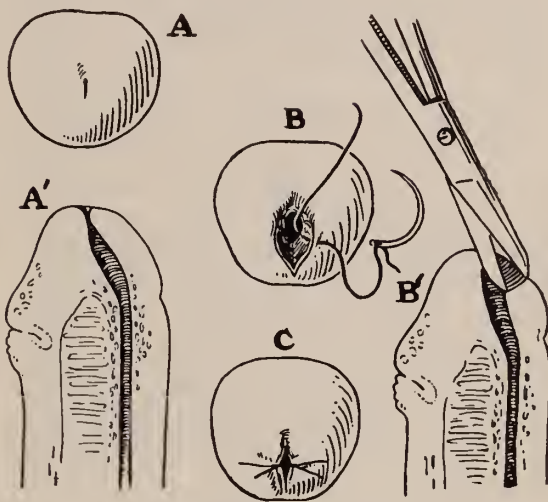


FIGURE 4.—Meatotomy.

A, A', minute meatus.

B, meatotomy with scalpel. B', meatotomy with scissors. If the gland is tightly squeezed as the cut is made, the incision is usually painless.

C. Suture of the urethral mucosa to the skin of the gland to prevent closure of the orifice by healing. The suture is unnecessary in children if one will keep the urethra well dilated following meatotomy as described in the text.

TIGHT MEATUS

A tight meatus is a frequent accompaniment of a tight prepuce. The condition is seldom recognized unless the calibre of the orifice is so small as to cause pronounced urinary difficulty, or in later life the patient acquires gonorrhea. The tight meatus becomes ulcerated and bleeds; or with drying of the ulcerated area, an incrustation or scab forms over the opening. This incrustation may seriously impede urination; or tearing the scab from the penis may be followed by profuse bleeding. Blood on the child's clothing or in the urine alarms the parents and they hurriedly call the physician. I am aware that Brenneman and some others still contend that the ulcerated or incrustated meatus is simply the result of ammoniacal diapers—ammoniacal urinary decomposition. Yet I have seen this lesion in boys

long out of diapers, and have yet to see a single instance of the condition not associated with an extremely tight meatus. Nor have I seen a case of ulcerated meatus which could not be readily and permanently cured by liberal meatotomy and the maintenance of the meatal opening at a normal size (10-12 F. in young boys).

The technic of meatotomy is simple, as indicated in Figure 4. One firmly grasps the glans penis and with a hard pinch for counter-irritation, quickly incises the meatus toward the frenum with a small scalpel. Bleeding usually stops promptly; but if it does not, slight local pressure for a few minutes suffices. No dressing is needed, but the newly incised edges must be periodically (seven to fourteen days) dilated a few times to an adequate calibre with steel sounds (12-18 F.) to prevent sealing together again of the meatus.

STRICTURE OF THE URETHRA

Ninety-five per cent of urethral strictures are the late result of gonorrhea; the remaining five per cent are either congenital or traumatic. Periodic dilatation of the constricted urethra with steel sounds is the conservative treatment of urethral stricture, and should be employed as far as possible. Operation, either internal urethrotomy or external urethrotomy according to the location of the stricture (anterior urethra or bulbo-membranous junction areas respectively), is to be reserved only for those cases not responding to dilatation by sounds, or in which such instrumentation is technically impossible.

Having cut the stricture, periodic progressive dilatation with sounds must be carried out to prevent growing together again of the margins of the incised stricture ring and a resultant scar more dense than before. A stricture is cured only when it remains adequately dilated; and the neglected stricture is ever a Damoclean sword over the head of its bearer. Even when the stricture is thought cured, urethral dilatation with sounds once a year is excellent life insurance. The method of passing sounds is well known to most practitioners; it is extremely important to adhere to the roof

of the deep urethra as the sound approaches the triangular ligament, in order to avoid pocketing of the tip of the instrument in the depression-pocket on the urethral floor as indicated in Figure 5. A guiding finger in the rectum is often helpful.

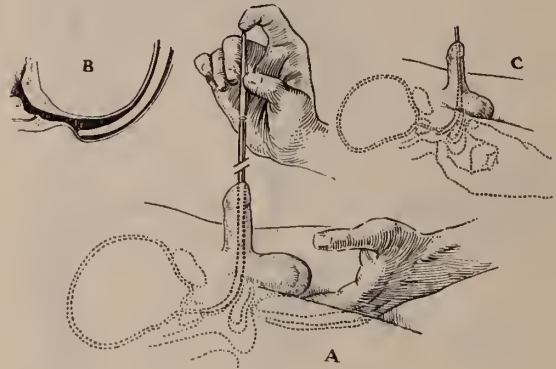


FIGURE 5.—Passage of Sound

A. With finger on the perineum to guide the instrument into the membranous urethra.

B. Tip of instrument caught in pouch of urethral floor at bulbo-membranous junction.

C. Finger in rectum to help overcome difficulty in B.

PROSTATITIS

Most prostatitis is non-venereal. I am aware that this statement is contrary to the belief of 90 per cent of medical practitioners, yet our observations as urologists daily bear this out.

The prostate may be infected through the meatus by sexual contact, or by the introduction of bacteria on unclean instruments. But most non-gonorrheal invasions arrive in urine from *infected kidneys* and bathes the posterior urethra; or the organisms reach the prostate hematogenously from infected foci elsewhere in the body—especially dental or intestinal. Moreover, it will be found that in the treatment of prostatitis, any patient not showing satisfactory improvement in three weeks should be referred to the *dentist* for search for focal infection. In a surprising number this study will prove most fruitful; and with the eradication of the dental focus of infection, prompt response to local therapy will occur in the prostate.

Of the organisms found in the infected prostate, the *staphylococcus* is by far the commonest. It is true that in many cases of gonorrheal prostatitis, secondary invading staphylococci cause persistence of the clinical manifestations and maintain prostatitis for some time after the gonococci have disappeared. The fundamentals of treating all types of prostatitis are quite the same. The first is *gentleness* of therapy: in the acute stage of the prostatitis, no instrument should be introduced except for catheterization in acute retention, and here prostatic abscess probably exists. Vigorous or rough treatment of the prostate is almost certain to engender complications and increased morbidity.

When the process is no longer acute, gentleness in passing instruments through the prostatic urethra, and gentleness in carrying out prostatic massage, are prime considerations. It must be remembered that the prostate is likely to be super-sensitive, especially the first time or two that it is massaged; and that undue therapeutic enthusiasm and effort are frequently followed by splanchnic shock, often with fainting.

It is important to emphasize that prostatic massage is often of extremely questionable value in many cases of prostatitis, and its employment in urologic disease in general is greatly overdone.

In massaging the prostate, the gentle stripping or pressure should begin at the tip of the seminal vesicle on each side and be carried down to the prostatic apex, avoiding as far as possible direct forceful pressure over the verumontanum in the mid-line. Three or four gentle strokes of the prostate and vesicle on each side may be considered sufficient massage.

Heat applied as hot Sitz baths, hot rectal irrigation, or by deep diathermy, will often give much relief. In some instances of non-acute prostatic inflammation with referred low backache or deep perineal pain, endoscopic application of silver nitrate to the verumontanum and deep urethra often bring prompt relief. Yet this procedure should be carried out only by one having considerable experience in urethral instrumentation.

Vaccine therapy in prostatic infection is of dubious value, and is employed by no recognized urologist I know of.

It must be appreciated that, with prostatitis, there is likely to be seminal vesiculitis, and the treatment of one structure involves the treatment of the other. In other words, treatment of the prostate alone is almost certain to be fruitless.

EPIDIDYMITIS

Epididymitis is more commonly gonorrheal than non-gonorrheal; but regardless of the etiology, the principles of treatment during the acute stage are essentially identical. The patient should be put to bed. Greatest relief will be achieved by the application of an adhesive suspensory which immobilizes the scrotal contents in high position and thus relieves the vas deferens of the drag caused by the infected, swollen epidymis and congested testicle. Injections of sodium iodide, calcium chloride, vaccines and so forth have all been employed; but we have found the *adhesive suspensory* with rest in bed superior. An ice cap over the swollen parts and the administration of anodynes such as aspirin may afford added relief. The treatment of epididymitis by this method is included under office treatment because at least half of these patients will be first seen in the office. The construction and application of these dressings are indicated in Figure 6. If pain or fever do not subside within three or

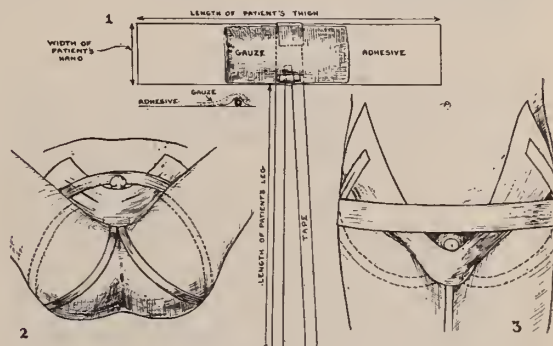


FIGURE 6.—Scrotal Suspensory Devised on the Urologic Service of Bellevue Hospital

This bandage is the most satisfactory for its purpose. It affords high immobilization of the scrotal contents, thereby relieving the inflamed vas deferens of any pull by the weight of the inflammatory testiculo-epididymal mass.

four days, epididymotomy is indicated. In chronic epididymitis, no treatment is necessary other than the wearing of a support to relieve the vas deferens of the vesicular drag.

URETHRAL INFECTION

Although gonorrheal invasion of the urethra is by far the commonest form of urethritis, as a urologist, and since the introduction of sulfanilamide and its kindred compounds, I encounter more non-venereal urethral infections. Most non-venereal, or so-called non-specific infections, are caused by the staphylococcus—either albus or aureus;—yet colon bacillary, diphtheroid, streptococcal, or even pneumococcal (oral infection) urethritis is not infrequent. The treatment of the acute stage of gonorrheal and non-gonorrheal urethritis is essentially the same. At the present time, chemotherapy by mouth with *sulfanilamide* and its series has outstripped all other methods in popularity. Yet it is of curative value in not more than 30 per cent of the cases. Unquestionably, these newer drugs lessen the duration of the disease in most cases and minimize complications. Nevertheless, sulfanilamide is not specific therapy for urethritis, and a distressingly large number of patients apparently show no bactericidal response to the administration of large amounts of the drug. Equally important, many patients are harmed by taking the large quantities of sulfanilamide which are sometimes given even in the face of unfavorable local results and systemic reaction.

URINARY INFECTION

The treatment of urinary infection by *chemotherapy* is an important phase of urologic office practice. Here we have a choice between the new antiseptics of the sulfanilamide group, and of the mandelic acid series. The specific bacteriologic indications for the various drugs must be keenly recognized and met. Calcium mandelate is my first choice when bacteriologically indicated, but I am aware that sulfanilamide gets first call by the majority of physicians. In any case in which the urine cannot be sterilized by three to four weeks of intensive chemotherapy, a complete urologic examination is indicated. In most instances major urapathy will be dis-

covered. The commonest type lesion is obstruction which is located somewhere along the urinary tract, and which helps, by causing urinary stasis, to maintain unilateral or bilateral infection.

No patient with urinary infection should be considered cured until at least two negative cultures of aseptically collected specimens have been obtained. The proper method of collection of the specimen for examination has been previously indicated. To collect specimens by any other method is to confuse the findings by infected debris. No amount of vulvar scrubbing is bacteriologically adequate, and the trauma of scrubbing far surpasses that of gentle catheterization under visualization.

HORMONE THERAPY

During the past five years endocrine therapy has rapidly gained prominence in certain types of urologic disease, notably the imperfectly descended testicle, hypo-gonadism, and adenomatous hypertrophy of the prostate.

ENDOCRINE TREATMENT OF CRYPTORCHIDISM

The administration of the anterior pituitary-like element of pregnancy urine has been employed for the past seven years in the treatment of imperfectly descended testicles. In a great many instances, phenomenal results have been obtained. Yet it is important to recognize that any case of undescended testicle complicated by hernia is at once a surgical problem. Unfortunately many patients with undescended testes have been given enormous quantities of the anterior pituitary-like hormone of pregnancy urine despite large hernias. For example, I have seen a boy who had literally been given over \$2,000 worth of the hormone, ineffectively, and despite a congenital inguinal hernia into which two fingers could readily be passed. In short, the hernial aspect of this anomaly has not been adequately appreciated and much valuable hormone has needlessly and fruitlessly been administered. It must be remembered that approximately 85 per cent of all undescended testes are accompanied by congenital hernia. This hernia, however, is not always discoverable by cough-impulse; frequently it is demonstrable only at the operating

table. When the hernia can be demonstrated by physical examination, the case should be considered surgical, and endocrine therapy used only to assist the operative therapy.

In many cases the pre-operative administration of adequate amounts of anterior pituitary-like hormone, or of testosterone propionate, will cause considerable glandular and genital enlargement, and sometimes sufficient to cause an abdominal testicle to descend into the internal inguinal ring where it is more readily accessible. When this has been accomplished, the patient is operated on. Postoperatively, the hormone is again administered to encourage genital and general physical development of the boy.

It is important to appreciate the limitations of hormone therapy in this field. If the hormone treatment is unsuccessful with the administration of 5,000 units, operation is recommended. I am aware that some children have been given as high as 20,000 units before mobilization of the testicle was evident, but the great majority of testicles favorably influenced by this treatment will show improvement with less than 5,000 units. Mechanical factors retaining the testicles in abnormal position will regularly be found when the gland is uninfluenced by hormone injection. These factors are usually local peritesticular adhesions; but in some instances the external ring is absent, or there is no inguinal canal. Abnormally high attachment of the gubernaculum may also be a factor in improper testicular descent.

Some writers advocate the postponement of surgical attack upon the undescended testicle until the boy reaches puberty. I strongly disagree, for by hormone administration we have at our command a method of determining at any prepubertal age what may be expected of the boy's cryptorchid when puberty arrives. Moreover, in bilateral cryptorchidism it is desirable to place testes down in the scrotum as early as possible, and not later than the fourth or fifth year. It is known that about 90 per cent of bilateral cryptorchids are sterile, and only by getting the testicle down into the cooler surrounding of the scrotum will the gland be given maximum opportunity for spermatogenesis later.

In unilateral mal-descended testicle, it is advised that the surgical treatment be undertaken before the child is eight years of age, since pubertal changes begin at this time. In other words, delay of the testicle in reaching the normal confines of the scrotum encourages testicular atrophy and aspermato-genesis. Surgically, we recommend some variety of the Torek two-stage operation.

ENDOCRINE THERAPY IN ADENOMATOUS HYPERTROPHY OF THE PROSTATE

The control of adenomatous hypertrophy of the prostate by hormonal injections is decidedly in the experimental stage. To date testosterone propionate has been used almost exclusively in the experimento-clinical observations in this field. Naturally every man with prostatic obstruction wishes to avoid an operation if he can; and particularly is this true of physicians, most of whom readily turn to hormonal therapy at the discovery of adenomatous prostatic obstruction. The results of this treatment are extremely variable. Favorable effects usually stimulate those obtained by x-ray therapy, viz., there is moderate decongestion of the enlarged prostate, with some diminution of urinary frequency and added comfort in the vesical area. Yet bladder emptying shows little or no improvement as indicated by the amount of residual urine. Moreover, these therapeutic effects are transient and are usually lost in three or four months. Although the patient may feel more comfortable, his urinary obstruction and renal injury consequent to the urinary back-pressure persist, and his course is decidedly downhill. For the present, therefore, we can only conclude that hormonal therapy is no proper substitute for surgical removal of prostatic obstruction.

ENDOCRINE THERAPY IN HYPOGENITALISM

Many cases of hypogenitalism, particularly of the Frohlich's variety, will be encountered in boys in office practice. The administration of the anterior pituitary-like hormone of pregnancy urine, or of testosterone propionate, is frequently of decided value in transforming the obese indolent boy with feminine body contour into a virile masculine individual of male

figuration. Although I have experimented in limited measure with the administration of hormone by inunction, I still feel that in these cases the greater certainty of the hypodermic method recommends its employment whenever possible.

SUMMARY

In the foregoing paragraphs, the commoner types of urologic disease which are daily encountered in the office of general practitioners have been discussed. The conditions which can be properly treated in the office have been indicated; surgical complications entail hospitalization of the patient. With due care, and proper

skill and diagnostic acumen, correct diagnosis and therapy can usually be achieved in the office.

I would again emphasize that urinalysis is the diagnostic keystone in most of these cases. Urinary infection is cured only when negative cultures of at least two aseptically collected specimens are obtained.

A stricture along the urinary tract is adequately treated only when it stays dilated, and free urinary drainage is unquestionably established.

Advances in endocrine therapy are opening new fields; its present status demands that our enthusiasm be well-bridled.

140 East 54th Street

NEWER DEVELOPMENTS IN QUALITY MILK PRODUCTION

By JOHN G. HARDENBERGH, V.M.D.

Director of Laboratories, The Walker-Gordon Laboratory Company, Inc., Plainsboro, N. J.

Read before the Section on Pediatrics of The Medical Society of New Jersey, 174th Annual Meeting, Atlantic City, June 5, 1940.

It is the purpose of this paper to discuss some of the developments in the production of high-quality milk as affected by our changing concepts of sanitation and nutrition. Our thinking changes as the horizons of technical knowledge broaden. This fact applies especially to our ideas about cow's milk in its relation to the health and nutritional well-being of children and adults.

Naturally, I speak not from the viewpoint of the pediatricist but rather as one who has had opportunity to observe some of the marked changes in the theory and practice of the production and handling of milk especially adapted for babies and children. In reviewing the most significant period in the history of modern milk supplies, that is, the past fifty years, the fact stands out that the medical profession in general and pediatricians in particular have been directly responsible for or closely associated with the most fundamental improvements in milk quality. This is readily under-

standable because cow's milk and its products have not only served long as staple human foods but because cow's milk in some form has been practically indispensable in the feeding of infants who are deprived of mother's milk.

The list of those in the medical field who have influenced thought and action concerning pure milk in its relation to child health and nutrition is long and imposing. To mention only a few: Holt, of New York, whose keen observations influenced more than a generation of pediatric teaching and practice; Coit, of our own State of New Jersey, whose concept of clean and pure milk to reduce infant morbidity and mortality was embodied nearly fifty years ago in Certified Milk, sponsored then and ever since by the medical profession; Rotch, of Boston, whose ideas and ideals about pure milk came to the front at the same time, whose percentage method of milk modification for infants brought to that practice a precision formerly lacking and whose laboratory methods

of preparing formulas led to the organization of a well-known dairy organization.

There are also Freeman, of New York, who first applied bacteriological methods to the control of Certified Milk, who developed one of the first small-mouth milk pails, devised an early apparatus for the home-pasteurization of milk and who is still active in Certified Milk supervision; the late Alfred Hess, also of New York, famed clinician and investigator in the field of rickets, who felt that the excellent results obtained by him and others in feeding a high-quality milk to infants could not be explained entirely on the basis of its sanitary excellence. It was Hess whose interest stimulated research into the nutritional character of the milk in question, the results of which confirmed his surmise that the milk had superior nutritive qualities. There was also Park, of New York, noted bacteriologist and student of disease, whose special abilities and wide interests in all phases of human health inevitably led him to contribute much to the development of wholesome milk supplies and to methods of protecting them. These and a host of others of your profession, both past and present, have left indelible marks upon the record of quality milk production.

What is being done today and what may be done tomorrow to effect still further improvements? Perhaps this phase can best be viewed by reference to a few of the past accomplishments that highlight the many developments in milk quality.

1. PASTEURIZATION

The introduction and extension of this process as a safety measure is too well recognized to justify elaboration. It has given a high factor of safety to large volumes of market milk that could not have been adequately protected otherwise. Thereby it has contributed an untold measure to the health and well-being of countless babies and adults. It is *not* an absolute safeguard and should not be heralded as such. When efficiently done, it confers such a high degree of safety from milk-borne diseases that its universal application to milk offered for sale in this country is probably an inevitable and desirable conclusion.

Recent years have seen reappraisal of the short-time, high-temperature method of pasteurization which fell into disrepute many years ago under the name of "flash" pasteurization. The present increasing attention to the method is based on vastly improved heating and control mechanisms susceptible to a precision of operation not formerly possible. The newly developed short-time, high-temperature methods are already approved in a number of states and cities and by the U. S. Public Health Service; in some places it is not approved. A temperature of not less than 160° F. for sixteen seconds is utilized, compared with 143° F. for thirty minutes in the universally accepted holding method of pasteurization. The short-time, high-temperature treatment has been proved effective and seems especially adaptable and suitable for the pasteurization of quality milks such as Certified with its initially low bacterial content.

A most useful test to check the efficiency of pasteurization has been perfected within the past few years. This is the so-called *phosphatase test* which is based on the inactivation by heat of the enzyme, phosphatase, always present in unheated milk. The destruction of this enzyme by heat seems almost perfectly correlated with time and temperature requisite to proper pasteurization of milk by either the long or short methods. The phosphatase test is proving most useful both for milk plants to control their operations and for inspectors to check the proper heat treatment of pasteurized milk.

2. CERTIFIED SYSTEM OF MILK PRODUCTION

This method of insuring wholesome milk, originally conceived and continually fostered since the beginning by members of the medical profession and by their officially organized societies, continues to play an important rôle in almost every significant improvement made in methods of milk production and handling. The sanitary aspects of quality milk production have been so well worked out that, in recent years, the major emphasis of Certified Milk methods has been placed on the nutritional properties of the milk. This aspect presents the newest, most significant and most promising

phase of endeavor for future quality development in the dairy field. Responsible for it is the "newer knowledge of nutrition", the recognition of accessory food factors as vital to the proper nutrition of man and animals.

These essential elements or vitamins cannot be measured in terms of the usual chemical constituents of foods but require special assay methods. Just as in most infectious diseases the harmful effects of an infection cannot be explained by the mere physical presence of the bacterial cells or virus agents alone but rather by their chemical or toxin-producing activities, so in a somewhat similar way, we have learned that the biologic effects of foods are not all accounted for on the basis of the ordinary chemical components. The far-reaching effects of foods depend upon their content of vitamins, and it is this fact that has given new impetus to improvements in milk quality.

Milk is known to be a rich source of certain vitamins, a fair source of others, but is deficient in some. The significant fact is that cow's milk is susceptible to a degree of control or improvement in its vitamin content by controlled feeding of dairy animals. The most striking example of this is the production of vitamin D milk by the feeding of irradiated yeast to cows. Moreover, improved methods of growing and preserving forage crops has resulted in significant increases in the content of cow's milk in vitamin A. The methods of preserving forage crops, such as alfalfa, by artificial dehydration or by the addition of molasses or certain acids have not only proven to conserve the vitamin content of such foods in a superior way, but they are also eminently practical and economical.

Another improvement, characteristic of the care taken to conserve the biologic properties of quality milks such as Certified, is the realization that prevention of oxidation, and contamination of milk with metallic substances, especially copper, may have an appreciable effect on nutritive values of the product.

These are just a few of the examples that might be cited to indicate the trend in modern methods of producing and handling milk. The result of these and other observations make it apparent that in the near future, perhaps this

year, the official Methods and Standards for the production of Certified Milk will provide for definite nutritional standards, the first requirements of the kind to be applied to any grade of milk except the well-known Vitamin D milk that has been available for some years.

3. HEALTH SUPERVISION IN DAIRY CATTLE

From the beginning, the importance of healthy dairy cattle has been recognized as a prime requisite to wholesome milk. At first, attention was centered on bovine tuberculosis. The tuberculin test for dairy cattle, introduced into this country in 1892, has proved a highly accurate diagnostic measure. The past twenty-five years have seen its application extended under a well-conceived and well-executed plan with the result that bovine tuberculosis has been practically eradicated throughout the United States. Consequently, it has ceased to be a menace to human health and a once-common plague of bovine animals.

The virtual elimination of the bovine type of tuberculosis has been supported by medical, public health and livestock sanitary authorities as a human and animal health measure and has also received support from agricultural and dairy leaders as an economic measure. Carried on in a coördinated manner by the official and private veterinary forces of the nation under Federal-State coöperation and guidance, bovine tuberculosis eradication stands out as a unique accomplishment in livestock disease control. Its contribution to human health are well known to you.

Somewhat analogous to the bovine tuberculosis problem of years gone by, Brucellosis has now come to the front and is being attacked with measures similar to those used to control the former disease. Brucellosis in cattle is also known as Bang's disease or abortion disease; in man, as Malta or undulant fever.

Nationwide tests reveal that the infection is present to some extent in about half of all the dairy herds in the country and that approximately 10 to 15 per cent of all the cattle in the country are reactors to specific agglutination tests for Bang's disease.

The serum agglutination test is an accurate diagnostic method and widespread testing and

elimination of reacting cattle has been under way for the past five years. Certified herds such as ours have been under test, with any reacting cattle removed, for ten years or more.

Bovine mastitis is the third major condition affecting the health of dairy cattle which is pertinent to this discussion. Bovine mastitis is essentially a milk quality problem and not a human health problem except in those very rare instances when human types of streptococci gain entrance to the bovine udder and set up an inflammatory process. The interrelationships of human and animal diseases and the significance of milk in their transmission are quite well understood today. We know the essentials for protecting well-supervised milk supplies by competent medical supervision of employees and competent veterinary supervision of cattle. We know that pasteurization will furnish protection for market milk supplies that cannot be given adequate medical, veterinary and sanitary supervision at the source.

Rapid progress is being made today in the methods for accurate differentiation of organisms associated with bovine mastitis. Effective control measures are being developed as diagnostic methods improve and the herds producing the higher quality milks are in a strategic position to apply these measures and so elevate their standards still another notch.

4. PROCESSING TO IMPROVE QUALITY

In addition to those things that may be done with dairy animals to improve the quality of milk by hygienic or nutritional control measures, study has been given for years to certain physical methods that may favorably alter the food value or digestibility of the product. One of the most recent of these developments relates to the curd character of cow's milk.

A number of methods are available which will reduce the curd tension of milk. Some

cows produce a milk of relatively soft curd, and soft-curd milk based on natural selection has been available for several years. There are also the enzyme method, the base-exchange method, and others.

Recent intensive studies of homogenization of milk indicate that this process has definite advantages. By subjecting cow's milk of average curd test to sufficient pressure by mechanical homogenization or by sonic vibration, a product is obtained in which the butterfat is evenly dispersed and the curd tension is reduced to a point that compares favorably with mother's milk or with evaporated milk when ingested. Homogenized milk has just recently been introduced into the Philadelphia and Trenton areas, following two or three years of research under medical auspices both from the laboratory and clinical standpoints. It offers very definite advantages to the pediatrician who desires to use a fresh fluid milk of low-curd tension and increased digestibility.

Homogenized milk must be pasteurized; and it has been found that when the pasteurization is done at about 150° F. for thirty minutes holding time, an excellent soft-curd value is obtained.

SUMMARY

In conclusion, it is evident by now that this discussion is not a technical consideration of the many phases of quality milk production. An attempt has been made only to review in a general way the significant developments in which members of the pediatric profession, on the one hand, and the producers of quality milk on the other, have joined efforts in the interests of improved human health and nutrition, especially for babies and children. The results have certainly justified the combination of energies, and the record of past achievements should offer a further stimulus and challenge to those in your profession and to those engaged in production of quality milks.

SCIATIC AND LOW BACK PAIN,—THE DIAGNOSTIC VALUE OF AIR MYELOGRAPHY

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From the Department of Neurology and Neurosurgery, headed by Dr. Temple Fay, and the Department of Radiology, headed by Dr. W. Edward Chamberlain. Read before the Section on Radiology at the Annual Meeting of The Medical Society of New Jersey, June 5, 1940.

Sciatic and low back pain may result from many causes. A thorough history, physical examination, and laboratory studies will reveal those due to intrapelvic disease or malignancy, prostatic tumors, lesions of the skeletal system, or systemic disease causing neuritic symptoms.

Often after extensive studies, the above abnormalities are not found, and it is necessary to treat patient symptomatically.

Since the reports by Schmorl, Goldthwaite, Middleton, and Teacher, and many others, there has accumulated enough evidence that a prolapse or herniation of the intervertebral disc in the lumbar region is one definite cause of sciatic pain.¹ The physician would like to exclude this lesion, but he is reluctant to expose his patient to the intraspinal injection of lipiodol because this substance is a foreign body, often irritating to the cord, roots, and meninges. If the lipiodol studies are negative, the patient must carry this foreign substance in his spinal canal permanently. Even if operation is done, the lipiodol cannot be entirely removed.

By injecting air into the spinal canal, the physician has a conservative and harmless method by which he can visualize these herniated discs. Dandy, Van Wagenen, and Coggeshall and von Storch have suggested the use of air to visualize the spinal canal, but did not report any cases of disc herniation.^{2,3,4} In 1937, the writer and Dr. B. R. Young cautioned the profession against the needless use of lipiodol, outlined the technic of air myelography as done in the clinics of Dr. Temple Fay and Dr. W. Edward Chamberlain, and reported a case of sciatic pain showing classical neurological findings in which, for the first time, prolapsed disc was visualized and recog-

nized by air myelography and verified by laminectomy.⁵ Again, in 1938, we published our technic of air injection, and reported, among thirteen verified lesions of the spinal canal, three cases of herniation of the intervertebral disc.⁶

Up to May, 1940, sixteen patients in Dr. Fay's Clinic, complaining of low back and sciatic pain, and who had defects in air column suggesting a herniated disc or obstruction in lower lumbar sac, came to operation. Eleven had a herniated disc, three had a hypertrophy of the ligamentum flavum, one had an arachnoiditis of the cauda equina, and in one, large epidural veins compressed the dural sac. In every case a definite lesion was found, accounting for the defect seen in the air column.

We believe that air myelography is indicated in any patient with persistent low back and typical sciatic pain who exhibits decrease or absence in the achilles reflex and in sensation, especially to pin-prick, heat or cold over the dorsum of the foot, or impairment of muscle power in the foot, and in whom no cause of the pain can be found.

Surgeons have at times visualized with lipiodol a typical defect caused by herniation of the intervertebral disc and failed to find the protrusion at operation. They attributed this to the return of the disc to its normal position because of the flexed position of the patient on the table. After the injection of air, we have taken films of our patients in normal flexion, extreme flexion, and hyperextension. We have clearly shown in some cases that during normal flexion, the disc protrudes into the canal; and that, following hyper-flexion of the thighs and back of the same patient, the disc returns to its normal position; and finally, if

the patient's back is hyperextended, the disc then herniates to its maximum extent.⁷ We call this type of disc a mobile disc, and feel that it is this mechanism of moving back and forth on flexion or hyperextension that explains the remissions of the attacks of pain (Fig. 1). The mobile type of disc should be treated by the orthopedic surgeon with a cast in the flexion position. The fixed disc should be removed by laminectomy.



Fig. 1.—Mobile intervertebral disc. A, note slight protrusion of disc in hyperflexion; B, marked protrusion in hyperextension. Intermittent left sciatic pain.

TECHNIC OF INJECTION

The patient is placed on his side on a horizontal x-ray table, equipped with a Potter-Bucky diaphragm, and a pillow or sandbag is put under the upper thorax. This elevates the spinal canal and permits the head and neck to lie at a lower plane than the uppermost thoracic vertebrae, thus permitting large quantities of air to fill the entire thoracic canal without ascending to the head and causing headache.

Lumbar puncture is then done with an 18-gauge needle at the third lumbar interspace. Spinal fluid is removed in five-c.c. amounts, and replaced by five c.c. of air or oxygen (the latter is absorbed quicker). At least 40 to 50 c.c. of the gas should be injected to insure

adequate filling and the needle withdrawn. This air column now extends from the point of puncture to the first or second thoracic verte-



Fig. 2.—(A) Displacement of the posterior longitudinal ligament dorsal by a herniated intervertebral disc at the fourth lumbar interspace. Note the narrowing of the interspace. At operation the sac below the protruded disc was almost obliterated by the resultant arachnoiditis. Compare with normal configuration of post-longitudinal ligament as seen in (B).

brae and cannot enter the head as long as the head lies at a lower plane than the upper thoracic vertebrae. If a lesion is suspected in the thoracic region, stereoscopic lateral and anteroposterior projections are taken. Oblique views are added if the upper thoracic spine is x-rayed, since the tracheal shadow would be superimposed in the other positions.

Where sciatic pain is the complaint, the examiner must visualize the lumbo-caudal sac because 90 per cent of the herniated intervertebral discs occur at the fourth and fifth lumbar vertebrae.

Since the air has been "trapped" in the thoracic canal by the technic just mentioned, one has merely to elevate the buttocks about 35 to 40 degrees from the horizontal and remove the pillow from under the thorax. The lumbo-caudal sac is now the highest part of

the canal and the column of air shifts to this region completely outlining the sac from the first sacral vertebrae to at least the lower thoracic vertebrae.



A B
Fig. 3.—Lumbo-caudal myelography in a case of "sciatic neuritis". Ober fasciotomy and pyri-formis section with no relief. Nucleus pulposus defect shown above uncovered by laminectomy. Films taken with patient in Trendelenburg position; 20 c.c. air injected. A, normal caudal sac; B, nucleus pulposus defect.

Stereoscopic lateral and antero-posterior projections are taken of the lumbar and upper sacral spine where possible. Additional stereoscopic lateral projections with the patient in extreme flexion and hyperextension should be taken in order to see whether the defect (if present) is decreased or increased by these positions (Fig. 1). In the normal case, the hyperflexion is seen to flatten the contours of the

ventral surface of the sac; while hyperextension produces plainly visible bulging of soft tissue contours into the canal opposite each intervertebral disc (Fig. 2B). We believe that this phenomena may explain remissions in pain. That is, when the disc slips back to normal position, the pain disappears; only to recur when it slips out again. The diagnosis of a herniated disc rests upon a defect produced on the ventral surface of the air column (Fig. 2A), which also may be seen on the antero-posterior projection (Fig. 3B).

The Department of Roentgenology believes that good contrast and detail are necessary in air myelography, and have found that "over-exposed" films give the greatest information. Accordingly, they raise the kilovoltage from eight to ten above that necessary for spinal detail.^{8,9}

CONCLUSIONS

Air myelography is a conservative and harmless method of visualizing space-taking lesions of the spinal canal. The defect produced by a herniated intervertebral disc is easily and accurately seen in an air myelogram done under proper injection and x-ray technic. There is no indication for the use of lipiodol, which will remain in the spinal canal permanently if operation is not done.

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THE CARE OF THE CHRONICALLY ILL IN NEW JERSEY

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Director of Medicine, New Jersey State Department of Institutions and Agencies
Abstract of an address before the New Jersey Health and Sanitary Association, November 15, 1940.

The subject of the chronically ill in New Jersey has been assigned to me. How large is the problem? No one knows, for there are no reliable figures for the State as a whole.

NUMBER OF CHRONIC CASES

Essex County has been rather thoroughly studied by the *Committee on the Care of Chronically Ill* of that county, and it found 1,249 cases known to 76 agencies, and estimated a total of 4,500 cases in the county.

The New Jersey Relief Census of 1937 found 3,852 "physically disabled" cases (which included chronic disease) in the county. Applying either one of these figures to the State as a whole, we might expect to find 15,000 to 16,000 chronics in need of care in New Jersey. This is exclusive of the mental and tuberculous patients who are already in hospitals.

The estimates of the National Health Survey tell us that there are probably 924,600 chronic invalids in the United States (including mental and tuberculous), among which New Jersey would have not less than 29,000 chronics. As a matter of fact, we know we have in our mental hospitals and tuberculous sanatoria 19,339 patients which, added to our estimated 16,000 outside of institutions, gives us a total of 35,339 chronics.

I believe, then, that we are on the conservative side when we say that, exclusive of the mental and tuberculous cases, New Jersey needs to plan for not less than 20,000 persons (not by any means all invalidated from employment). Of these, about 85 per cent are above 55 years of age, and about 8.8 per cent are under 34 years of age.

Therefore, the bulk of our problem of care and treatment must revolve, at the present time, around the group over 55 years of age, already seriously handicapped. But there is a tremendous problem of *prevention* which needs to be initiated at once if we are to control the problem of the chronically ill.

DEATHS FROM CHRONIC DISEASES

One word more might be said in relation to death from chronic diseases. The Essex County Survey states that in 1938 there were 6,264 deaths in that county from chronic disease. Applying that figure to the total population of New Jersey, we should expect 27,800 deaths. Actually in 1936 we lost approximately 30,000 in the chronic disease classifications, with total deaths that year from all causes of 44,659.

The social implication of these deaths cannot be disregarded. The loss of time from work, the family disorganization, and the costs of medical care to the family and the taxpayer are enormous.

PREVALENCE OF CHRONIC DISEASES

The broad classification of "chronic disease" covers a multitude of conditions. Boas enumerates 28 broad classifications ranked in terms of days lost from work; he also classifies them as to rank in terms of invalidity and death. The causes of chronic disease also vary, including bacterial, metabolic, toxic, allergic, new growths, etc.

KINDS OF CHRONIC DISEASES

Dr. Boas, quoting from Bulletin No. 6 of the preliminary reports of the National Health Survey, gives us the relative prevalence of specific diseases, according to four indices. In the following table I quote only the upper twelve classifications out of the total of twenty-eight.

The incidence of chronic disease becomes greater as the income of the individual or family is lowered. The incidence rate of chronic disease for the country as a whole was estimated by the National Health Survey as 48 per thousand for all income groups. For the relief family the incidence ran as high as 71; for those with incomes under \$1,000 it was 54; and for the income of \$3,000 and over it was 38 per thousand.

Chronic Disease	Rank According to			
	Estimated Days Lost 1937	Estimated Number of Invalids 1937	Estimated Number of Cases 1937	Estimated Number of Deaths 1937
HEALTH SURVEY—Census Bureau				
Nervous and mental	1	1	10*	7
Rheumatism	2	2	1	14
Heart disease	3	3	2	1
Arteriosclerosis and heart disease, high blood pressure	4	5	3	3
Tuberculosis, all forms	5**	4	15	5
Cancer and other tumors	6	9	13	2
Nephritis and kidney disorders	7	7	9	4
Disorders of female organs	8	10	14	15
Hay fever and asthma	9	8	4	19
Disorders of gall-bladder—liver	10	12	17	8
Diabetes mellitus	11	6	16	6
Ulcers, stomach—duodenal	12	14	20	10

* If the estimate of these diseases were complete, this group would probably rank seventh.

** If the estimate of this disease were complete, it would probably rank fourth.

RANK OF SPECIFIC DISEASES ACCORDING TO FOUR INDICES

AGENCIES CARING FOR THE CHRONICALLY ILL

Where do we stand today in New Jersey in our care of the chronically ill?

The Department of Health has already begun a vigorous program of education in relation to cancer and venereal disease, strengthening the hands of the medical profession in their control.

The Department of Institutions and Agencies, in coöperation with the New Jersey Tuberculosis League, has carried on a vigorous education for laymen and the medical profession, covering prevention and cure over a long series of years, with extremely satisfactory results.

Mental hospitals are filled to capacity and with an encouraging recovery rate. *The Mental Health-Community Clinic* program, even when we add to it the work of the *Maternal and Child Health Division of the Department of Health*, is but the beginning of attack on an enormous problem which tends to grow greater, rather than less, as the tensions of modern life increase.

The Department of Public Instruction is only now beginning to recognize its responsibility for mental health in its training of teachers, and its application of the principles of mental hygiene in the schools.

OBSTACLES

What is our situation as to the remainder of the 28 broad classifications of chronic disease? The answer is that we are pretty much at loose ends.

General hospitals are reluctant to receive these patients; and they place a time limit on the length of stay of chronic patients after the acute exacerbation has been improved. Moreover it is the rare staff man who is keenly interested in the chronically ill, even from the research point of view.

Relief administrations are disposed to limit the amount of service they are willing to approve for compensation to physicians and visiting nursing organizations and pharmacists.

Nursing organizations themselves are obliged during epidemic periods to restrict their care of chronics in favor of the acutely ill because of limitations of their staffs. One cannot quarrel with this policy. One can quarrel with the apathy of public agencies and the charitable public that sufficient money is not supplied to insure larger staffs to provide the service through these agencies.

Hospitals for the chronically ill are almost non-existent except in urban centers. Welfare houses in a very few counties (Morris, Monmouth, Passaic among them) meet a part of the need for chronic care for indigents.

Nursing homes licensed by the Department of Institutions and Agencies are scattered in almost every county in the State. Under the direction of physicians they do a creditable piece of work, but they are hard-pressed to maintain our prescribed standards when relief and county welfare agencies seek to beat down the rate of \$2.00 per day for care which we have learned during twelve years of experience is the minimum at which good service can be rendered.

With these limitations on available facilities, the major number of chronic patients is neglected, or they are treated in their own homes by physicians and nursing organizations who are most inadequately paid for their services. Facilities are available only in *some* areas, but not all; and they are used only by *some* local and county public welfare officials and overseers, but not by all, even though the Municipal Aid Administration has authorized the inclusion of costs for medical care rendered by physicians, nurses, dentists, hospitals and pharmacists, as part of relief costs.

The Medical Society of New Jersey has offered the services of the medical profession on a sound social and economic basis, and the Municipal Aid Administration has approved the plan. The nursing, dental, and pharmaceutical professions are ready to cooperate through their State organizations. The State Hospital Association is seeking to meet a public need through individual hospitals, while at the same time it must see that the hospitals remain solvent.

The "bottle-neck" in the streamlining of care for the indigent sick lies in the *local community* (five hundred and sixty-three local communities in New Jersey), where tax funds for the relief office are often lacking; and where, in many of our smaller communities, there is as yet no recognition, on the part of the overseer's office, of medical service to the poor as a public responsibility.

Such being the case, where do we go from here?

FUTURE STEPS

There is need for statesmanship in the broad fields of the professional services; in the state

official agencies of health and welfare; and in the local health and welfare agencies which should bring to the service of the people the knowledge and skills with which New Jersey is richly endowed in the care of the sick and the promotion of health.

Here are some of the steps which we must take if we are to solve the problems of care of the chronically sick:

1. Develop coördination of administrative machinery on the local level in order to bring together the patient, the facilities, and the funds with which to pay for services rendered the sick, subject to State supervision. The county is the logical unit for effective functioning of such a plan.

2. Expand the educational program already undertaken by the State Department of Health to include the major classifications of chronic disease, directing this education not only to the medical profession, but to the public.

3. Promote further development of the County Welfare House (authorized by law since 1924) providing the institution with a medical staff and the equipment to serve certain types of chronic illness, as well as to give custodial care to the aged.

4. Expand existing county and municipal general hospitals for the service of the chronically ill.

5. Make an experimental approach to the establishment of wards for chronic patients within the administrative structure of general hospitals.

6. Provide public support of tumor clinics and increase the number of those which are connected with general hospitals, encouraging their use by the public and the medical profession; or, if this is impossible, promote the establishment of a central State institution.

7. Encourage dispensary clinic service for chronic diseases in general hospitals, for the benefit of the indigent and sub-marginal income group.

8. Instruct physicians and medical students in the care of cases of chronic illness.

Unless we do all of these things, we shall fail to serve the people who have need of our service; and the mounting relief load, caused by chronic illness, will crush the taxpayer.

VOCATIONAL REHABILITATION OF THE TUBERCULOSIS PATIENT

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From the Medical Service of Valley View Sanatorium, Paterson, N. J.; Stephen A. Douglass, M.D., Superintendent and Medical Director. Read before the Spring Conference of the New Jersey Tuberculosis League, Asbury Park, June 2, 1939.

Lee¹ demonstrated the influence of poverty on the tuberculosis incidence rate; and Heise² included the mode of life among such factors. Following recovery, the physician is still concerned with the economical status of his patient, since poverty is a cause of relapse.

thirty-four patients discharged with their consents and capable of gainful employment were traced. The employment record of these is shown in tables I, II, III. The percentage relations are based upon all years combined, and upon the rate of reemployment existing at the

TABLE I

FOUR HUNDRED AND THIRTY-FOUR PATIENTS DISCHARGED BETWEEN 1929-1938 INCLUSIVE AND RATED ACCORDING TO THEIR HEALTH CONDITIONS.

	Employed	Unemployed	Relapsed
Rest cures	69.1	11.2	19.0
Thoracoplasty cures	68.1	6.8	25.0
Phrenectomy cures	65.0	5.0	30.0
Pneumothorax cures	63.4	19.0	17.6
Far advanced	56.2	13.3	30.5
Moderately advanced	70.0	9.5	20.5
Minimal	76.3	12.9	10.8
Sputum positive on admission	61.8	11.4	26.8
Sputum negative on admission	71.9	11.7	16.4

TABLE II

FOUR HUNDRED AND THIRTY-FOUR PATIENTS (same group as in Table I) RATED ACCORDING TO THEIR EMPLOYMENT AFTER THEIR DISCHARGE FROM THE SANATORIUM

	10	20	30	40	50	60	70	80	90	100
White collar										
Light labor										
Own housework										
Heavy labor										
Character of work unknown										
Employment not necessary										
Federal-State projects										
Total relapse										

TABLE III

PERCENTAGE OF EMPLOYMENT OF 75 PATIENTS NOT IN THE SANATORIUM, ON WHOM PNEUMOTHORAX WAS PERFORMED

	10	20	30	40	50	60	70	80	90	100
Total out-patient pneumothorax (75)										
Employed										
White collar										
Light labor										
Own housework										
Heavy labor										

Information has been collected concerning reemployment of the successfully treated cases at Valley View Sanatorium over the years 1929-1938 inclusive with the purpose of determining how well the recovering patient has been able to readjust himself to society assisted as he has been by the usual sanatorium facilities for such purposes. Four hundred

time when the information was secured, which was May, 1939. Under Table II the group, considered as being adequately placed without the necessity of gainful employment, included youths of school age who had returned to their studies, and adults with sources of income.

From these percentage relations evaluated on the basis of social type of the individual and

character of the community industry, both of which exercise an influence, certain conclusions can be drawn. A part of Passaic County, located as it is on the margin of the New York metropolitan area, is residential, and at least a part of these persons are engaged in white-collar work within the county or commute to similar work in the cities. However, a large majority of the patients received at the Sanatorium have been employed in textile, rubber, dyeing, or aeroplane plants. Much of this work can be classified as light labor. The hours worked per day seldomly exceed eight.

Under these industrial and social conditions, pneumothorax recoveries relapse less frequently than recoveries by any other means. Next in order is rest alone, then thoracoplasty and phrenicectomy. While the employment rate remained near the same for the different treatment methods, the variation in relapse rate was startling and supports a growing opinion that rest alone, or rest plus pneumothorax, is the most successful phthisiotherapy.

If in the female childbirth is contemplated, or if in any case return to gainful employment is contemplated, and if the disease character and extent is not of the most desirable for rest treatment alone, pneumothorax should be resorted to, childbirth permitted, and reemployment freely recommended. A 30 per cent relapse for phrenicectomy cases indicates that this means of treatment should be used less frequently. Phrenicectomy cases usually fall in the moderately advanced group and a cavity with positive sputum ordinarily exists. This may exercise some influence on the frequency of relapse, but rapid closure of the cavity following phrenicectomy may occur, and a tendency to shorten the subsequent period of bed rest for this reason, in addition to inadequate compression of the diseased area, exercise a greater influence.

The outlook for thoracoplasty-treated cases is even worse, considering that on the average, sputum conversion can be expected in 65 per cent of any group treated, and that 25 per cent of the sputum conversions are expected to relapse. However, thoracoplasty offers a suitable means of recovery to a small, well-selected group of patients who have not recovered by other means; and failure to tolerate employ-

ment exhibited in the group studied is accounted for largely by over-optimistic case selection. The relapsing case usually had extensive disease and a poor general condition when operated. When disease extent is considered, one recovering from a minimal tuberculosis has almost a one-third greater chance of becoming employed than the far-advanced case, and 300 per cent less chance of relapsing. In like manner, if the sputum was positive when treatment was instituted, the patient as compared to the sputum negative case, was less likely to become employed, and relapse was almost twice as frequent. The employment of ambulatory pneumothorax patients following discharge as apparently arrested is distinctly permissible.

The problem of relocating the successfully treated tuberculous patient in society in a manner that life can go on without relapse is real. Sixty per cent of the average sanatorium population of the country have progressed no further than the grade school;³ and considering that the average age of sanatorium patients is rising rapidly, this alone would make any comprehensive program of reeducation into fields of lighter endeavor most difficult.

A 21.2 percentage relapse of all cases discharged is high, although near the national average. Almost in every instance relapse can be associated with child-birth, excesses in life, poor economical conditions, and heavy labor. The latter two of these, poor economic conditions and heavy labor, are the only causes for relapse that could be remedied by vocational reeducation. If coöperative communities are not established, then direct relief to those unable to secure suitable employment is indicated until such employment is secured. This will assist many cases over the early post-sanatorium months during which their disease is becoming more securely healed. When bed facilities are available, a policy of extending the sanatorium residency until the disease is more securely healed may be advisable.

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VITAMIN K IN OBSTETRICS

MATERNAL WELFARE ARTICLE NUMBER FIFTY-FIVE

By ARTHUR W. BINGHAM, M.D., East Orange, N. J.

This brief article is presented in order to call attention to the work which has been done in determining the value of vitamin K in preventing hemorrhage in the newborn.

Waddell and Guerry published a paper in the A. M. A. Journal of June 3, 1939, showing that hemorrhages of the newborn are due largely to the slow prothrombin clotting and blood clotting times found during the first few days of life. It was shown that vitamin K administered to the baby immediately after birth served to hasten the clotting time and thus check such hemorrhage. It was also suggested that, in cases of necessary operations on infants during the first week of life, vitamin K should first be administered.

A number of articles have been published since, and the most recent is one by Hellman, Shettles, and Eastman of Baltimore, published in the American Journal of Obstetrics and Gynecology of November, 1940. It is a review of one year's experience with vitamin K in obstetrics.

The article should be carefully read by all physicians taking obstetrical cases. The authors conclude that the best method of giving vitamin K to prevent hemorrhage in the newborn is to give it *to the mother* during labor. The authors believe that such a practice, properly timed and with suitable dosage, will nearly eliminate so-called *hemorrhagic disease of the newborn*, as well as certain types of cerebral hemorrhage.

Beck, of Brooklyn, in the discussion of this paper, corroborated the findings of the authors.

The method followed was to give two mg. of the synthetic vitamin K (*2-methyl-1, 4 naphthoquinone) by mouth during labor. Beck states that it may be repeated after six hours in long labors. Other investigators recommend giving one or two milligrams each week during the last month of pregnancy; but Eastman and Beck are not inclined to use it until labor starts, because they consider it safer, and its action is so rapid that the plasma prothrombin level is raised sufficiently to prevent the usual drop which occurs on the second and third days.

The prevention of hemorrhage in the newborn is so important that the administration of synthetic vitamin K in all labor cases should be seriously considered. No harmful effects have been noticed, and the number of hemorrhages have been greatly reduced. The synthetic vitamin K has been found to be more effective, and much cheaper than vitamin K complex. In the average case only one dose is needed; and this is given by mouth during labor. It would seem to be a simple preventive for a serious condition; but it should be used only by the method advised by those who have had experience with it.

* This preparation is called Thiloquinone by Squibb, and other names by various manufacturers. Two mg. may be given when labor starts; and then one mg. repeated in six hours if the patient is still in labor.

A LESSON FROM A DEATH CERTIFICATE

NUMBER TWENTY-SEVEN

Patient had prenatal care in hospital clinic with no abnormalities noted.

Admitted in labor with membranes ruptured. Had prolonged labor and finally cesarean section three days later. Patient promptly became septic and died four days later.

Two lessons are seen here:

1. If abnormality could have been discovered in clinic, elective cesarean might have been done.

2. Sepsis is almost sure to follow a cesarean done so late in labor. An extraperitoneal cesarean might have had better result.

A. W. BINGHAM, M.D.

STATE SOCIETY ACTIVITIES

TUBERCULOSIS CASE-FINDING

THE REPORT OF THE ADVISORY COMMITTEE ON TUBERCULOSIS

A DISCUSSION OF THE TUBERCULIN TEST, AND X-RAY PROCEDURES, WITH PARTICULAR REFERENCE TO SCHOOL SURVEYS

Conducted by ABRAHAM E. JAFFIN, M.D., F.A.C.P., Jersey City, N. J., Chairman, Advisory Committee on Tuberculosis of The Medical Society of New Jersey, at the Spring Conference of the New Jersey Tuberculosis League at Princeton, N. J., May 17, 1940.

I. TUBERCULIN TESTS

A. THE PATCH TEST

(Applied to the *surface* of the skin)

1. *How accurate is it?*

The patch test, used with correct technic, is apparently just as efficient as the Mantoux (intra-dermal) test up to 0.1 milligram tuberculin (O. T.).

2. *What are its advantages?*

- a. It is more popular with parents, students and school personnel, because it is painless.
- b. The technic is much simpler.
- c. It is less time-consuming.
- d. It is less expensive because it requires fewer doctor-nurses' hours.
- e. There is no trauma, and it never causes focal or general constitutional reactions.
- f. The nurse can be shown by the doctor how to apply it.
- g. It is made from tuberculin derived from a synthetic medium claimed to be three to four times as strong as the usual tuberculin produced from veal broth.¹
- h. It is sensitive enough for screening purposes.
- i. It can be used instead of the first intra-dermal test where two strengths of tuberculin (first and second) were planned. The reaction to the second, or higher, strength has always been found mild where the patch test had been negative.
- j. The Patch test material, kept in a cold, dry place, will remain reliable for one year.²

3. *What are its disadvantages?*

- a. It is less quantitative in its character.
- b. It is more subject to interference.
- c. It is probably subject to other factors influencing the reaction, such as defective preparation of the skin, loose contact, excessive wetting, the presence of

many hair follicles, or the moisture secreted by the sweat glands.

- d. It is less sensitive than 1.0 milligram O. T. (old tuberculin), or the second strength P. P. D. (purified protein derivative), intra-dermally.

4. *How extensively has it been used in New Jersey?*

It is rapidly replacing the intra-dermal test in many parts of the State.

5. *Have comparative testing technics been studied?*

Many comparative tests have been studied throughout the nation, and in New Jersey. (See conclusion at end of Section B.)

B. INTRA-DERMAL TESTS

1. *What are the recommendations in regard to the O. T. and P. P. D. tests?*

- a. O. T. and P. P. D. are both preparations of tuberculin for intra-dermal testing (Mantoux).
- b. They are both objected to at times, especially in surveys, because of the use of the needle.
- c. Intra-dermal reactions can be read in 48 hours, and represent a more exact and quantitative method.

2. *What are the recommendations in regard to the O. T. test?*

Because of considerable variation in the potency of some commercial preparations of O. T., there has been a good deal of dissatisfaction, for a long time, from many users of these products.

On the other hand, there are certain very potent non-commercial preparations put out by health departments and other laboratories which have been standard with many who have used them over long periods of time. As a consequence, those who have had long and satisfactory experience with

the latter have been slow to change to P. P. D. The low cost of O. T., the ease with which various dilutions can be made, and the duration of its potency for many months, have made O. T. the preparation of choice in many clinics.

3. *What are the recommendations in regard to the P. P. D. tests?*

Purified protein derivative is the product of long research by the N. T. A., aimed at providing a tuberculin derived from tubercle bacilli grown on synthetic media free from extraneous protein. In other words, the tuberculin itself is the purified protein derivative. It is at present being manufactured by two well-known drug houses,—Parke-Davis, and Sharpe & Dohme. It is more expensive, and must be freshly prepared since its solutions do not keep; but is more useful for the physician making only occasional tuberculin tests in his private practice, or where potent O. T. is not available. It comes in two strengths. It has been observed that a certain number of individuals who are negative to the first strength have suffered excessively severe reactions to the second. To avoid this, some

users have reduced the second strength one-half. There is need for modification of the present dosage.

Conclusion regarding the patch test. (See questions A-1 to 4 at the beginning of the article.)

Experience to date would indicate that, with proper precautions in the application of the patch test, it is not only as efficient as the intradermal test, but is more useful and practical both for the private practitioner and school surveys.

Care must be taken that the patch test is left on for at least 48 hours, so as to be removed by the nurse or physician. Failure to do so may account for some of the negative results reported as compared with the intradermal test. The latter is not subject to this interference. All tuberculin tests should be seen and interpreted by a qualified physician.

Occasionally one of the two test squares will react, or one may be stronger than the other. These are probably due to differences in skin preparations and subsequent contact.

Considerable variations may be encountered in reactions, "from a few small discrete papules to a large indurated and reddened area set with small vesicles".³

II. X-RAY PROCEDURES

1. *What are the recommendations in regard to x-ray facilities and technics? What are the comparable values of different technics?*

Recommendations in regard to x-ray facilities will vary with the several communities, depending upon their available facilities. These may be discussed as follows:

A. Stationary Facilities

1. The private roentgenologist.
2. The general hospital x-ray department.
3. The tuberculosis sanatorium x-ray department.
4. The fluoroscopic method.

B. Portable Facilities

5. Regular x-ray films.
6. The paper roll method (Powers).
7. The fluorographic method.
 - a. 4 x 5 film.
 - b. 35-mm. roll.

1. THE PRIVATE ROENTGENOLOGIST

An increasing appreciation of the importance of the routine x-raying of apparently well people is creating a rapidly growing demand for this method of examination for the early diagnosis of pulmonary tuberculosis. This is especially true for certain groups of the adult pop-

ulation, and all adolescents, such as teachers, school personnel, college, and high school students.

Where a small number of individuals is concerned, if satisfactory arrangements can be made with local roentgenologists, the services of the latter should be utilized. It would obviously be impractical, however, for the private roentgenologist to handle mass surveys involving large numbers. One of the more rapid and less expensive procedures would be more practical. The private roentgenologist can then better devote his time to the more important part of the undertaking, namely,—*the interpretation of the findings.*

2. THE GENERAL HOSPITAL X-RAY DEPARTMENT

In some localities, the facilities of the local general hospital can be used very satisfactorily. This can be done by sending small groups, by appointment, to be x-rayed at a minimal cost agreeable to the hospital authorities.

3. THE TUBERCULOSIS SANATORIUM X-RAY DEPARTMENT

The same method could be followed where a tuberculosis hospital is available.

4. THE FLUOROSCOPIC METHOD

The fluoroscopic method is mentioned here for no other reason than that it is also another method favored by some, that can be carried out with *stationary* apparatus. Routine fluoroscopic examination has in its favor "low initial cost, and cheap upkeep". In the opinion of Edwards⁴ et al.:

These advantages are outweighed by several disadvantages. Primarily, the diagnostic facilities are hampered principally by the human element. The fluoroscopic interpretation represents the *impression of a single individual* that cannot be reviewed by others, and it does not leave a permanent record that can be compared serially with subsequent examinations.

Fluoroscopy requires great experience, the best visual adaptation, actually takes more time than the making and reading of films, and requires considerable eyestrain in the darkroom. Fellows,⁵ of the Metropolitan Life Insurance Company, has used this method extensively in the routine examination of Home Office employees. In 2603 such examinations checked by x-ray film he reported an error of 13 per cent.

5. REGULAR X-RAY FILMS

As pointed out in the recent supplement to The American Review of Tuberculosis on Tuberculosis Casefinding,⁴ the x-ray unit must in most cases be one that is easily movable. It must be brought within convenient access of the population to be served, or serious difficulties are sure to follow. Thus, the stationary unit is limited to a given location. It also has further limitations in that the speed of operation at best is restricted, requiring considerable accessory equipment such as cassettes, and a corps of technicians, so that in a day the technical work would in the end be uneconomical."

"The portable x-ray unit is a low-priced mechanism that is easily transported from point to point. Its capacity is inadequate, to secure the quality of film we desire, and it requires the same accessories as a stationary unit. Furthermore, it is limited in its capacity for large-scale service."

6. THE PAPER ROLL METHOD (POWERS)

"Since 1933, the Department of Health (of New York City) has utilized the Powers Rapid-Paper X-ray Method because it has been the only device incorporating the factors of accurate diagnosis, portability, speed and ease in subsequent handling of films. There has been a certain amount of objection offered against paper x-ray films by the radiologist and clinician, chiefly from those who have never used the method or who are acquainted with the paper film of several years

ago. A similar objection was offered about twenty years ago when the celluloid film replaced the old glass plate. * * * There has been since that time a vast improvement in emulsions used so that a similar comparison today would undoubtedly elicit a response similar to that of Myers⁶ and our own opinion which is entirely favorable. Comparative studies with paper and celluloid on identical chests revealed that for all practical purposes the two media were equally good. Any question raised on paper was equally a question on celluloid, and demanded further clinical study before a definite conclusion as to its significance could be reached."

With the rapid-paper method there is greater speed. "The paper film can absorb a wider variation in kilovoltage than celluloid. This is a factor of great consideration in survey work where there may be fluctuation in the line current, and there are always possibilities in time variations. There is less eyestrain in reading, permitting a greater unit volume of work in a stated period. The keeping qualities of the paper film have been observed over a period of seven years, and are considered satisfactory." At an average rate of 125 films per hour, in an eight-hour day 1000 individuals can be x-rayed. The films can be read by two men simultaneously, at the rate of 200 or more an hour with little fatigue or strain. The only objection to these paper films is their bulk in filing. This may, however, be overcome by filing reductions at a very nominal cost.

7. THE FLUOROGRAPHIC METHOD

There are now in course of development two other methods for less expensive x-ray surveys. Both are attempts to photograph the fluoroscopic image;—one on a 4 x 5 film, and the other on a miniature 35-mm. roll.

A. THE 4 x 5 FILM

The 4 x 5 method is made on individual cut films, which must be changed for each exposure. This takes a little longer than the time required to turn the roll for another exposure on the 35-mm. film. This method is made possible by a very special foreign-made lens, which is extremely limited in number at the present time. The life of this lens is said to be shortened by deterioration following prolonged exposure to the x-ray, and the effect of the same on the cement holding various layers of glass together.

The 4 x 5 method is not available excepting by purchase. This involves buying an x-ray machine, a special highly sensitive screen and camera. The cost of this equipment exclusive of the x-ray machine is \$2500. To this must

be added the expense of a special truck and chauffeur for transportation as well as that of a technician, and the processing of the films. The individual films are quite inexpensive, however, and less bulky in filing.

B. THE 35-mm. ROLL

The 35-mm. method is also portable. The exposures are made similarly, but on small photographic rolls. This service is available without the purchase of the apparatus, and delivers developed films at the cost of 65 cents per person. This is ten cents cheaper per film than the 14 x 17 paper picture, in quantities of 400 or more. They are also less bulky in filing.

Both methods require enlargement of the original for interpretation, especially the 35-mm. method; but they suffer from a definite haziness involving a loss of detail. This is particularly true of the 35-mm. film. Because of their size, they are, therefore, less easily read than the 14 x 17 picture.

"While these methods have possibilities as a means of examining large groups of people quickly and economically, they have not yet advanced to the stage of development where they can displace the 14 x 17 paper film."⁷ Whatever advantages they may have are at the expense of detail.

III. WHO PAYS FOR X-RAY SERVICE OF PUPILS AND ADULT SCHOOL EMPLOYEES? IF BOARDS OF EDUCATION CANNOT FINANCE X-RAYING, WHOSE RESPONSIBILITY IS IT?

IN COUNTIES WHERE A SANATORIUM HAS PREVIOUSLY FURNISHED X-RAY SERVICE, CAN THE COMMUNITY COUNT ON ITS CONTINUANCE?

Under the new laws in New Jersey, the Boards of Education are responsible for the elimination of tuberculosis from their schools, and may pay for the x-ray services involved.

The cost of x-raying students can be tremendously reduced by preliminary tuberculin-testing. In the average school district, only about 25 per cent would be found tuberculin-positive, needing an x-ray. The number of employees being so much smaller, and the incidence of infection so much higher, tuberculin-testing may be dispensed with in adults entirely, and all x-rayed at the same time.

Sanatoria usually have enough to do in the care of their own cases, and should not be subjected to the burden of mass surveys with the consequent disruption of their own routine. However, the doubtful cases needing rechecking on clear-base films should be referred to them or to the private roentgenologist.

Where very small numbers are involved, local sanatoria could probably be used to mutual advantage. Inasmuch as in the end the taxpayer supports both schools and sanatoria, it would make very little difference which organization assumed the cost of excluding tuberculosis from schools.

IV. A. WHAT IS A FAIR PRICE FOR CELLULOID X-RAYS?

B. WHO SHOULD READ THE X-RAYS?

C. COST OF READING.

A. PRICE OF CELLULOID X-RAYS

The use of celluloid films for survey work is expensive. The high cost is due not only to the fact that the individual films cost more, but the method takes much more time. Celluloid films might be found practical in localities where only a very small number are to be surveyed, and hospitals or sanatoria are willing to coöperate without profit at a cost covering film and processing. In some instances local roentgenologists might be willing to aid at a nominal rate per film. Where a large number of individuals is concerned, the use of regular x-ray films would make the cost excessive and unwarranted.

B. WHO SHOULD READ THE X-RAYS?

The interpretation of x-rays of apparently well individuals as encountered in tuberculosis

surveys of high school students, teachers, etc., reveals findings that require the greatest care and considerable experience in their proper evaluation. It would, therefore, be desirable for the roentgenologist to read these films jointly with a qualified phthisiologist.

C. COST OF READING

The cost of reading x-rays is likely to vary with each community. One must look at it, however, from the standpoint that most of the films will represent a group of apparently healthy people, the majority of whose films will be within normal limits, and that these surveys are made as a part of a Public Health Service. This service is not to be rated in the same manner as the interpretation of individual films in the practice of medicine and roentgenology.

The cost should be kept at a Public Health level, and not according to the standards of private practice. Paper films as used in most large surveys can be read easily and satisfactorily at the rate of about 200 or more per hour.

With these facts in mind, the cost will depend upon the number of films to be read, and the fees agreed upon between the school boards and the physicians qualified and willing to do the reading.

V. WHO SHOULD KEEP RECORDS?

TO WHOM SHOULD REPORTING BE MADE?

WILL RECORDS OF TESTING BE AVAILABLE FROM BOARDS OF EDUCATION TO TUBERCULOSIS ASSOCIATIONS FOR PURPOSES OF EVALUATION?

In school surveys, records should be kept by the medical department, which should in turn send reports of the findings to the family physician of each employee and student. These results should also be made available to the

local tuberculosis league for statistical purposes. Those in charge of surveys should also see to it that all proved cases of reinfection tuberculosis are reported to the local Board of Health by their physicians.

VI. WHAT PART SHOULD TUBERCULOSIS ORGANIZATIONS PLAY IN THE TESTING X-RAY PROGRAM?

SHOULD WE OFFER TO CONTINUE WITH THE EDUCATIONAL PROGRAM? IS A PRE-TESTING EDUCATIONAL PROGRAM OF VALUE?

For the present, as well as for some time to come, tuberculosis organizations should continue to play their important rôle in educating the public to the value of the examination of all apparently well individuals over fifteen years of age, for the purpose of discovering

pre-clinical tuberculosis. If our school laws are properly enforced there may be no need for educational programs for pre-testing. However, it would probably be wiser to make educational programs on tuberculosis an established part of a health program in all schools.

VII. A. THE LAW STATES THAT "EVERY BOARD OF EDUCATION SHALL REQUIRE A PHYSICAL EXAMINATION OF ALL EMPLOYEES OF THE BOARD AT LEAST ONCE IN THREE YEARS." IS IT ADVISABLE TO AMEND THE LAW TO MAKE THE RECOMMENDATIONS OF TESTING AND X-RAYING, OR DIRECT X-RAY SERVICE, MANDATORY?

B. IF THE TEACHER ELECTS TO HAVE HIS OWN PHYSICIAN GIVE THE PHYSICAL EXAMINATION, CAN HE RECEIVE THE TESTING OR X-RAY SERVICE AT SCHOOL AND BE INCLUDED IN THAT BUDGET?

C. SHOULD THE COST OF X-RAYING AND READING OF TEACHERS AND SCHOOL ADULTS BE THE SAME AS PUPILS?

A. The law requiring a physical examination of all employees at least once in three years is reasonable and sound. However, it must be emphasized again, that no physical examination can be considered complete so far as the exclusion of communicable tuberculosis is concerned without an x-ray of the chest. A proper appreciation of this fact makes the chest x-ray indispensable and therefore mandatory.

Recent supplementary regulations issued by the State Board of Education May 11th, 1940, relieve the situation somewhat, and simplify the requirements by accepting an x-ray of the chest as compliance with the law. However, in one paragraph of this supplementary regulation there is a large defect, permitting the acceptance of a certificate of good health without an x-ray. This should be changed by making an x-ray mandatory, and the sole special requirement.

B. If the teacher elects to have his own physician give the physical examination, the report should be accepted, provided it is accompanied by an x-ray of the chest, both subject to the approval of the medical department of the school and its x-ray expert respectively.

The School Board should not be called upon to pay for such individual and private services for teachers, for the following reasons:

1. It might result in a diversity in quality of service.
2. It would be much more expensive.
3. It would be much more time-consuming.
4. The rapid x-ray service method on the premises would overcome all these disadvantages.

5. The per capita group survey fee would be inadequate for any private physician.

C. The cost of the x-raying and reading of teachers and school adults should be the same as of pupils.

VIII. WHAT FINANCIAL RESPONSIBILITY HAS A SCHOOL BOARD TOWARD ITS ADULT PERSONNEL IN THE EVENT OF AN EXTENDED PERIOD OF ILLNESS FROM TUBERCULOSIS?

The financial responsibility of a School Board toward its adult personnel, incapacitated by tuberculosis, is obviously no different than it would be under similar circumstances from other diseases.

IX. HOW CAN THE PROBLEM OF X-RAYING OF BUS DRIVERS WHO ARE NOT EMPLOYEES OF THE BOARD, BUT WHOSE SERVICES ARE CONTRACTED, BE MET?

A clean bill of health should be required of bus drivers;—and this is to include an x-ray of the chest, as a part of their contracts. Tuberculous bus drivers can be a real source of infection to the passengers—especially to their regular patrons.

X. IN REGARD TO 9-10-11-12th GRADE PUPILS, THE LAW STATES THAT "THE BOARD OF EDUCATION OF EVERY SCHOOL DISTRICT SHALL PERIODICALLY DETERMINE OR CAUSE TO BE DETERMINED, THE PRESENCE OR ABSENCE OF ACTIVE OR COMMUNICABLE TUBERCULOSIS." HOW OFTEN IS "PERIODICALLY?" WHAT ARE THE RECOMMENDATIONS AS TO FREQUENCY?

In the initial application of a tuberculosis survey, whether by law or otherwise, all the students in the 9th, 10th, 11th, 12th grades should be tuberculin tested, and *all* positive reactors should be x-rayed. Thereafter, at least once a year, all new students should be tuberculin-tested, together with *all* previously negative reactors.

After each periodic tuberculin-testing survey, *all* reactors should be x-rayed, including

those x-rayed in previous surveys. Ordinarily such surveys are made annually either in the Spring or Fall.

New students admitted midterm, between surveys, should be tuberculin-tested, if possible; and x-rayed if positive, promptly, without waiting six months for the next periodic survey. Wherever possible, junior high schools should be included in these surveys.

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BUSINESS MANAGER TO THE MEDICAL SERVICE ADMINISTRATION

Mr. Joseph J. Harty has joined the operating force of Medical Service Administration as Executive Secretary. Mr. Harty is a graduate of Lafayette College, class of 1927, and has held responsible positions as a business executive, with emphasis on sales management and promotion. He will act as business manager for Medical Service Administration, which plans to start active operations on March first, 1941.

THE MASS IMMUNIZATION OF PRE-SCHOOL CHILDREN

By CHARLES V. CRASTER, M.D., D.P.H., Health Officer, Newark, N. J.

With the mass immunization of the children in our schools and the virtual extirpation of diphtheria among school children, there still remained the problem of the pre-school child to be considered where contact was more difficult. With the organization and education of parents through the school child the problem of diphtheria immunization among them was easily solved. It was a question of energy and determination plus a publicity campaign.

Although parents were perfectly willing to have their children protected, there was a feeling among them that the younger members of the family could wait until reaching school age. It thus happened that sporadic cases of diphtheria appeared from time to time among this group of children.

Under ordinary circumstances, no health department has the necessary force to carry out a home-to-home check-up of such magnitude, and the Federal W. P. A. was appealed to for assistance in this meritorious health effort. Thanks to the Government Agency, a group of seventy-five investigators was assigned to the health department in 1936, to carry out a follow-up campaign among the families of the city.

A house-to-house canvass was made to ascertain the number of children in each family under school age not immunized, and to encourage the mother to send her children to the family physician for immunization.

50,000 FAMILIES CONTACTED IN TWO MONTHS

In the first two months of work, visits were made by the investigators to approximately 50,000 families. Among this group, 25,780 families had at least one child under six years. There were 36,518 such children. Every child was recorded and the record filed in our field headquarters by geographical districts. Among the 36,518 there were 19,456 who claimed to have been immunized, or approximately 55 per cent.

Of the 17,062 recorded as not immunized, 16,771 eventually signed consent slips. Upon the first visits of the investigators, there were 937 refusals. Repeated visits together with neighborhood education eventually reduced the number of parents refusing to 291.

PHYSICIANS' OFFICES OVERWHELMED

In the early months of 1936, all children were referred to the neighborhood physicians. By arrangement with the County Medical Society, a group of physicians had agreed to have a designated health hour once a week at which those families able to pay were charged one dollar for each injection of toxoid. For those unable to pay, no charge was made. The ability to pay was left to the discretion of the physicians.

As a result, however, of the intensive campaign for immunization, the physicians' offices were overwhelmed with children whose parents asserted they

were unable to pay. Ninety per cent of all children applying claimed indigency. The physicians found these applicants so numerous as to make them unable to take care of their private work. An appeal to the Health Department brought about the reopening of our clinics which had been closed for immunization work at the request of the physicians.

METHOD OF IMMUNIZATION EMPLOYED BY THE PHYSICIAN

The method of immunization adopted for the physician was two doses of toxoid at an interval of two weeks. The physicians had strongly urged that a follow-up Schick test be not stressed or even mentioned to the parents, basing this recommendation on the publicity which had been given to the efficiency of artificial immunization. They believed that a few unsuccessful immunizations would not justify the additional burden of the Schick test procedure, which naturally required an injection visit followed by a visit for reading.

When, however, this work was returned to the clinics, it was found that in many instances only single doses of toxoid had been given. The results of these immunizations was therefore so indefinite that it was considered very necessary to check up upon the amount of protection given by Schick tests. Among 2,000 children immunized by the physician and subsequently Schick tested, the positive reactions numbered 20 per cent of the whole.

A BACKLOG OF 16,771 CHILDREN UNDER 6 YEARS

With a backlog of 16,771 children under six years of age, the majority of whom were susceptible to diphtheria, efforts to speed up immunization were immediately undertaken. Free clinics were opened up in the Baby Welfare Clinics of the Department, throughout the city, and special physicians were assigned from the Department staff. Two doses of toxoid were administered with an interval of two weeks between injections. No routine Schick testing was attempted, as speed in immunization was the first important object to be attained. By November, 1936, of the 16,771 children whose parents had signed consent slips, approximately 10,000 had been immunized.

PRE-SCHOOL CHILDREN 82 PER CENT IMMUNIZED

It was estimated that 82 per cent of all pre-school children under six years of age in the city were immunized in 1936. This conclusion was arrived at in the following way: Our records show that among the total child population of the city under six years of age, 19,456 had previously been immunized prior to 1936. During 1936, 10,938 further immunizations were carried out during the year, making a total of 30,394.

As the survey showed 36,000 pre-school children under six years of age in the city, this left 6,000 not immunized. To this total had to be added, how-

ever, at least 4,000 children who had reached six months of age during the ten-month period. We had also to subtract at least 1,000 children reaching their sixth birthday who were not immunized, making a total of 9,000 un-immunized children. A further deduction of at least 3,000 children had to be made for those under six months of age, too young for immunization, leaving a total of 27,000 immunized children out of an estimated 33,000 between six months and six years, making an immunized total of 82 per cent.

THE W. P. A. PROJECT IN 1938

With the termination of the W. P. A. project in 1936, it was evident that the ordinary rate of immunization of pre-school children by the private physician and the clinics would not dent the large backlog of un-immunized children which steadily increased at the rate of 4,000 children per year.

In 1938, the W. P. A. came to our assistance with, however, a much smaller project. The staff consisted of thirty field workers and office staff, and eight physicians. Clinics were opened in our eighteen different Baby Keep-Well Stations, six each day between 1 and 3 p.m. The field work was so directed that an even stream of children should come to the clinic five days a week.

METHOD OF IMMUNIZATION

With no routine check-up upon the results of the previous immunization, it was impossible to gauge the efficiency of the method employed. In the new project it was decided to carry out a routine Schick test four months after the termination of the procedure. In considering the method of immunization to be adopted, some thought was given to the one-injection method with alum precipitated toxoid as suggested by the late Dr. W. H. Park (*American Journal of Public Health*, 1935, Volume 25, page 620).

Sufficient evidence was, however, not available at that time as to the duration of immunity to be expected of the method. The procedure finally adopted was the use of *two doses of toxoid*, with an interval of two weeks between each injection, and followed by a Schick test four to six months afterwards.

SCHICK TESTS SHOWED 42 PER CENT POSITIVE

During the year 1938, 7,949 children under six years of age were immunized by two doses of plain toxoid with an interval of two weeks between each injection. Of these, 7,193 were Schick tested, with 2,951 positive reactions, or 42 per cent of the total.

THE SCHICK MATERIAL WAS SATISFACTORY

There was something wrong somewhere; but what it was could only be determined by a thorough check-up of the material used and the methods of injection. If the negative Schicks following re-immunization were excluded, the proportion of positives after one series of treatment was as high as 50 per cent.

Several experiments were carried out to determine if the freshly diluted Schick material was better than the material purchased ready-diluted.

Among 890 children tested with freshly diluted Schick material and control, the positive proportion remained the same. Another large group of approximately 1,000 children was Schick-tested with prepared material and control. There were but three or four pseudo reactions in the entire group, and the positive proportion was not affected. Inquiries made to the makers of the Schick material did not indicate that there had been any increase in the potency of such material which might have been responsible for our high positive rate after immunization. The high positive Schick rate greatly increased the burden of our work, making it necessary of course to re-immunize all the positives, who amounted to nearly half of the total immunized.

INTERVAL BETWEEN INJECTIONS INCREASED

Information from the biological houses producing the toxoid material did not disclose any weakening of the toxoid which might have reduced its power to immunize. Attention was next called to the interval between the two doses of toxoid as a possible cause of lack of efficiency. This interval was therefore increased from two weeks, to three weeks. In the group immunized with the three weeks' interval between doses of toxoid, subsequent Schick testing showed a somewhat lower positive rate of 30 per cent. This was, however, much too high. We came to the conclusion that two doses of this material was not sufficient to produce immunity as shown by the Schick test.

There was every indication, however, that sufficient immunity had been produced to ward off attacks of diphtheria. This was shown by the continual low incidence of infection among the immunized group. This was further evidenced by a group of 400 children who had been found positive by Schick test, were not re-immunized, yet among them no cases of diphtheria had developed.

CHANGE TO ALUM PRECIPITATED TOXOID

Several authorities had suggested that an increase from two, to three doses of toxoid given at weekly intervals, increased the potency of the treatment. This suggestion would, however, have made our work much more cumbersome and would have delayed considerably the rate of immunization.

Subsequently a change was tried to one dose of alum precipitated toxoid, followed by one dose of plain toxoid with a three-week interval between the two doses. The results of this change were immediate. Among the first group of 1,800 children immunized in this way, and subsequently Schick-tested, a positive rate of only four per cent was found.

TWO DOSES OF ALUM PRECIPITATED TOXOID

Volk and Bunney (*American Journal of Public Health*, March, 1939, Volume 29, No. 3) in their immunizing work among the children of Saginaw County, Michigan, reported satisfactory immunization by the use of two doses of alum precipitated toxoid at a three-weekly interval.

Furthermore, as the use of alum precipitated toxoid was found in our experience to have caused no excessive number of severe local reactions, it was

decided to substitute the second injection of plain toxoid with the alum precipitated material. The interval between the two injections may be extended to one month, as recommended by the Committee on Administrative Practice of the American Public Health Association. It is hoped that this procedure will further reduce the positive Schicks to the vanishing point. If this proportion can be brought down to one or two per cent, the Schick test will not be needed as a routine check upon immunization.

PRESENT ROUTINE PROCEDURE AND FOLLOW-UP

The present routine procedure carried out under this project, which has been continuous for the past three or four years, is as follows:

1. Shortly after birth, a Child Hygiene nurse calls with the birth certificate, and mentions immunization among her other advice to the mothers.

2. Child Hygiene nurses visit practically all babies once each month for first year of life, and three or four times each year of the next three years. She urges immunization constantly after six months.

3. At one year of age, a birthday congratulation card is sent with reminder of immunization if not yet done.

4. At two years of age, if not immunized, the name of the baby is referred to the Contagious Disease Inspectors, who make a special issue of it. A postal is sent to parents advising that an inspector will call.

5. When the child enters school, the school nurse takes up the task. At present, at least 90 per cent of the public school children and 95 per cent of parochial school children have been immunized and Schick-tested. The school nurse and doctors are Schick testing those children who were already immunized upon admission. All children with positive Schick tests are re-immunized.

6. Un-immunized children in classes while a case of diphtheria occurs are excluded for one week after report of such a case.

7. Two doses of alum precipitated toxoid at an interval of three weeks is the routine at present for all children under six years. For other children, three weekly doses of toxin-antitoxin is still the procedure.

Note: All of the above is in addition to the work of our W. P. A. project which mans the clinics and visits the homes of infants known by birth reports and child hygiene records. Their follow-up is of great aid in maintaining a high proportion of pro-

tection. The following table shows the prevalence and mortality from diphtheria for twelve years:

DIPHTHERIA					
	Cases	Deaths		Cases	Deaths
1928.....	1,364	95	1934.....	10	1
1929.....	1,717	96	1935.....	12	1
1930.....	873	48	1936.....	2	0
1931.....	226	16	1937.....	5	1
1932.....	70	2	1938.....	23	1
1933.....	21	1	1939.....	13	1

During 1940 there have been no cases and no deaths from diphtheria in the City of Newark.

SUMMARY

The procedure for mass immunization of pre-school children requires a special investigation force, such as that available under W. P. A. projects capable of making a house-to-house "round-up".

In 1935 a special group of seventy-five investigators thoroughly combed the city for un-immunized children under six years. Among 50,000 families visited, there was found 17,062 non-immunized children under six years of age. Among this group, 16,771 children were eventually immunized with two doses of toxoid with two-week interval between injections. No Schick testing was done following this immunization as speed was the most important object.

Among a group of 2,000 children a greater proportion immunized by one or two doses of plain toxoid, the Schick test showed 20 per cent positive. The results of immunization showed 82 per cent of all pre-school children had been immunized by the end of 1936. A similar W. P. A. diphtheria immunization project was granted in 1938.

The method adopted for this project was two doses of toxoid at an interval of two weeks, with a Schick test four months later. Among 7,949 children so immunized, the Schick test results showed 42 per cent of the total positive. A change of procedure to one dose of alum precipitated toxoid followed by a dose of toxoid three weeks later was followed by much lower positive Schick rate.

Among a group of 1,800 children so immunized the positive Schick rate was only four per cent. The procedure at present carried out is two doses of alum precipitated toxoid at an interval of three weeks between each dose.

Indications are quite strong that the proportion of positive Schicks following this type of immunization will be so small as to justify deferring the Schick test until child enters school.

ACTIVITIES OF THE STATE BOARD OF MEDICAL EXAMINERS OF NEW JERSEY

Presented by A. ANDERSON LAWTON, M.D., President, and
E. S. HALLINGER, M.D., F.A.C.S., Secretary

In the year 1890 the Legislature of the State of New Jersey created an administrative and executive body, which is known as the *State Board of Medical Examiners*. The members composing this Board are appointed by the Governor of the State after the various societies from which they come have presented a list of three names from which the Governor is to select one man to fill any existing vacancy. The function of this Board is to regulate the practice of medicine and surgery; to license physicians and surgeons; and to punish persons violating the provisions of the Medical Practice Act.

Since the creation of this body, enactments, amendments and supplements have changed the personnel of the Board until at the present time it is composed of five members of the old school, three homeopaths, one eclectic, one osteopath and one chiropractic member, a total of eleven but with a membership that consists of nine graduates of schools of medicine, who possess the degree of M.D. The term of office of these men is three years. From this set-up the Board elects a President, a Treasurer and a Secretary. The Board also has a common seal of which all Courts of this State shall take judicial notice.

The President or Secretary may issue subpoenas to compel the attendance of witnesses to testify before the Board, and to administer oaths in any matters pertaining to its duties. These subpoenas are issued under the seal of the Board, and are served in the same manner as those issued out of the Court of Common Pleas of the State. The penalty for refusing to be sworn and testify is \$50.00, to be sued for by the Board in any Court of competent jurisdiction.

The Board likewise makes rules and regulations, which are not inconsistent with the laws of the State or the United States, for the purpose of transacting the business and duties pertaining to the provisions of the article under which it operates. It likewise appoints an Inspector who is not subject to the provisions of the Civil Service law, and who acts as an agent of the Board and is authorized to serve and execute any process issued by any Court under the provisions of the Act. Briefly, when violations of the Medical Practice Act are re-

ported to the Board, they are referred to our Inspector, who sends out investigators to obtain bona fide evidence upon which to prosecute the offender. This evidence is then turned over to the Attorney General; and if it is considered sufficient, the violator is arrested and ordered to appear for trial.

The Board of Medical Examiners meets monthly in the City of Trenton, to conduct the business which comes regularly before it, to hold hearings of complainants represented by their attorneys, to give audiences to consider the credentials of certain applicants, and to conduct such other matters as are within its normal realm.

EXAMINATIONS FOR LICENSES

In June and October of each year examinations of applicants for licenses to practice medicine and surgery within this State are conducted. In order to be admitted to the examination an applicant must have been approved and certified by the Credentials Committee, whose function it is to investigate in minute detail all certificates, diplomas, and evidence that the applicants meet the complete prerequisites as set forth in the present Medical Practice Act. Examinees who obtain a general average of 75 per cent, and who do not fall below an examiner's mark of 65 per cent, are entitled to licensure within the State. However, any candidate who obtains a general average of 75 per cent or greater, yet falls below a mark of 65 per cent in any one subject, is entitled to reexamination in that one subject. Should a candidate fall below a mark of 65 per cent in more than one subject, he is deemed to have failed in the whole examination.

It is the mistaken belief that the Board has a wide discretionary field. This is wrong, and frequently creates attitudes which are unpleasant and embarrassing among the applicants, who cannot conform to the mandatory requirements of the act. Generally, however, the Board, in its deliberations and actions, weighs in the balance the evidence produced by the candidate against its mandatory and discretionary powers, and is liberal without jeopardizing the welfare of the people of New Jersey, which, in all honesty, it strives to serve.

HOSPITAL INTERNES

Today, the recent Medical Practice Act of 1939 requires all prospective internes of hospitals in the State of New Jersey to secure certificates from the Board, which are given upon verification of their medical education. This is a prerequisite to commencing their interne training.

RECIPROCITY

The Board likewise licenses practitioners of medicine by reciprocity with any state that has the same requirements that we demand; also those who have passed the National Board of Medical Examiners, provided, however, the candidates can meet the prerequisites of the New Jersey Board. The fee demanded in these instances is \$100.00.

LIMITED LICENSES

Since the original Medical Practice Act was passed, it has been amended to include osteopathy and chiropractic, and likewise to further provide for the licensing of midwives and chiropodists. Osteopathic physicians and chiropractors have been licensed by the State Board for many years, subject to the provisions of the act in force during those periods. When licenses are limited, we mean that these licentiates have a definite scope in which to operate, depending, for example, upon the definition as to what constitutes osteopathy and chiropractic. "Within the meaning of the provisions of Section 45:9-14.4, the practice of osteopathy shall include "the diagnosing, treating, operating, or prescribing for any human disease, pain, injuries, deformity, mental or physical condition; provided, however, that a license to practice osteopathy shall not permit the holder to prescribe, administer or dispense drugs for the internal use in the treatment of any human ailment, disease, pain, injury, deformity, mental or physical condition, or to perform surgical operations as require cutting." While, on the other hand, the practice of chiropractic is defined as "the detecting and adjusting by hand only of vertebral subluxations".

STANDARDS OF OSTEOPATHS

In conformity with the advancement of medical educational requirements the osteopaths have participated by raising their standards to that required of schools and colleges teaching medicine; and, at the present time, the Board does not license osteopaths as such, but gives them a certificate entitling them to practice medicine and surgery. The law under which

they received their original license for a limited practice was annulled in 1935, and the Medical Practice Act was amended to provide for the licensing of osteopaths by examination until July, 1939. This present law gives the right to practice medicine and surgery based upon a degree of D.O. given by a professional school or college teaching osteopathy and approved by the State Board of Medical Examiners. Those osteopathic physicians of this State who operate upon a limited license have until the year 1941 to qualify themselves for unlimited licenses by taking a special examination in pharmacology, therapeutics and surgery.

CHIROPRACTIC

The chiropractors have not, so far, raised their standards in conformity with the requirements of the new Medical Practice Act; and further, they have not coöperated in requesting inspection of their schools in order to obtain approval by the State Board of Medical Examiners. However, the Board has set a standard of requirements for a school teaching chiropractic which, if accepted and adopted, will make graduates of the same eligible for licensure by examination before the present Act becomes inoperative.

The Board may refuse to grant, or may suspend or revoke a license or the registration of a certificate or diploma to practice medicine or surgery filed in the office of any County Clerk of this State, under an Act of the Legislature, upon proof to the satisfaction of the Board that the holder of such license has violated the Act.

COMMITTEES

Within its body the Board constructs certain committees to whom it delegates various and particular duties, relating to the phases of enactment. The committees, in turn, present for consideration at the Board meetings evidence and facts which they have obtained.

Under later articles which will appear, there will be specific reference to the duties and functions of these various committees, such as the Illegal Practice Committee, the Committee on Education and Hospitals, and the Credentials Committee.

The Attorney General's office of the State of New Jersey assigns one of its representatives to attend the Board meetings for the purpose of interpreting legal phases of the law, and to act as an attorney in the hearings which are conducted before the Board. From time to time written opinions from the Attorney General's office are provided to the Board at the expense of great time and effort. The At-

torney General's office prosecutes and conducts all court cases against persons who have violated the Medical Practice Act. Without the generous assistance from this source it would be difficult indeed for the State Board of Medical Examiners to function.

ANNUAL REGISTRATION

We feel that the practitioners within the State borders should be thoroughly conversant with the functioning, duties, and powers of the State Board of Medical Examiners, whose objective is to protect the public and the physicians within our State against the acts of the charlatan and illegal violator. The State Board of Medical Examiners is a purely executive and administrative body and is not concerned

with legislation except as it assists in the administration of the Medical Practice Act. And in this connection, it is hoped that the medical fraternity in the State of New Jersey will see the desirability and importance, as a protection to themselves and the people, to enact legislation which will permit the *annual registration* of every practitioner within our State. By such system it is believed that many benefits will accrue to the medical profession. In those States which have inaugurated this procedure, reports of its success are universal.

The State Board of Medical Examiners welcomes the opportunity to be of assistance in any of the problems pertaining to the Medical Practice Act as it relates to all members of the medical fraternity.

MEDICAL PREPAREDNESS IN ELIZABETH, N. J.

The Medical Preparedness Division of the Mayor's Security Committee of Elizabeth, N. J., offers the following plan for medical action and coordination in the event of a catastrophe, sabotage, arson, war, or other public calamity in Elizabeth.

I. HOSPITALS AND SUPPLY CENTERS

The City of Elizabeth is extremely fortunate in having within its limits three large, modern and highly efficient hospitals. All three have been given a class A rating by the American College of Surgeons. While these hospitals, at present, are running to almost full capacity, they, together with the Alvin Eaton Memorial Hospital, have an expansion capacity of approximately two hundred beds or three hundred cots. Unfortunately, the hospitals themselves have very few available extra beds or cots, blankets, pillows, pillow-cases, and sheets. They can, however, very efficiently take care of all types of patients up to the capacity of their expansion within their own walls, as was definitely proved in several emergencies and disasters in the not too distant past, and must look to the Red Cross for extra equipment.

For any catastrophe or emergency that would definitely overflow their intra-mural capacity, arrangements have been made with nearby buildings such as St. Michael's Hall, Lutheran Church (East Jersey Street), Y. M. C. A., Y. M. H. A., St. Mary's Hall and St. Anthony's Hall, to accommodate approximately three to four hundred cots. All these buildings have adequate toilet and kitchen facilities and lend themselves easily to be set up as "Reception Centers".

If the emergency is of greater magnitude, a comprehensive survey of the entire city reveals the following available buildings, all with toilet and kitchen facilities:

- A. Grace Church.
- B. Westminster Presbyterian Church.
- C. Trinity Church.
- D. First Presbyterian Church.
- E. Third Presbyterian Church.
- F. St. John's Church.
- G. Christ Church.

The Elizabeth Armory has been used very efficiently on several occasions, and will no doubt be used again; but it is temporarily left out of the above picture because of the uncertainty of its availability at the exact moment of need. The various auditoriums of the schools of Elizabeth could, and probably would, be used by the simple process of removing the seats in them. When any of the above buildings are used, they will be designated as "overflow stations".

II. THE MEDICAL PERSONNEL

The physician in charge of the medical set-up shall be known as the *Medical Director*. It shall be his duty to:

- A. Completely coordinate the work of the physicians with:
 - a. The hospitals and hospital authorities;
 - b. The Red Cross;
 - c. The Police Committee;
 - d. The Transportation Committee;
- B. Report the workings and progress of the Medical Plan to the Mayor's Security Committee.

The Medical Director will assume charge of all patients admitted to any of the reception centers, or to the overflow stations. Those admitted to the regular hospitals of Elizabeth will be taken care of by the regular hospital staff in the same manner as civilians are now cared for.

From a volunteer list of over fifty qualified physicians, the Medical Director will appoint *four teams* of five men each to man the *Reception Centers*, which will be made up of the overflow from each of the three hospitals. A building nearest to each of the hospitals, and the Alvin Eaton Memorial Hospital, will be the first to be used. Others will be opened and used as necessary.

It will be the duty of each team to man, equip, and put into smooth operation its respective designated Reception Center. One of the five physicians thus appointed will be the Captain, and will assume charge of the Center.

The remaining thirty physicians will immediately be sent to the scene of action or disaster, in groups of three as the nature or severity of the emergency requires. All these physicians will be thoroughly trained in surgery.

Upon arrival, they will render First Aid, administer hypodermatically, control bleeding, render patients fit to be moved, and help generally in the evacuation of the sick and wounded.

They will be equipped with emergency medical kits; and with a set of red and set of white tags. These are for the purpose of writing the patient's name, address, telephone number; and most important of all, the treatment rendered and the disposition of the case. The tag is to be securely pinned to some part of the patient's body or clothing. This will eliminate the possibility of the patient receiving duplicate morphine injections, etc.

The red tag will be for seriously wounded patients, who should be sent without delay to the hospital proper.

The white tag is for those not so serious. These patients are to be sent to the Reception Centers, and then when these become filled, to other buildings known as "overflow stations" which will be opened up, properly manned, and equipped as needed.

When all the patients are removed from the scene of the emergency, the doctors will report for duty at one or the other of the Reception Centers, or to an overflow station, as assigned by the Medical Director.

No major operative work is to be attempted in the Reception Centers, or the overflow sta-

tions, unless absolutely necessary and unavoidable.

Because intra-venous therapy and blood transfusions will be in urgent demand, one or two physicians will be designated as a "transfusion team" and will be assigned to each of the Reception Centers. A list of donors, properly typed, will be supplied to each hospital, Reception Center and overflow station.

As the emergency subsides, the overflow stations will be the first to evacuate their patients, either to their respective homes, or to one of the hospitals, either directly or through the Reception Centers. When all patients have been evacuated, the doctors will be relieved, the equipment returned and accounted for, and the building restored to its normal use.

The Reception Centers, in turn, will gradually discharge their patients either to their homes, as cured, or to any one of the three hospitals that has available beds. When all patients have been evacuated, the doctors will be relieved, the equipment returned and accounted for, and the building restored to its ordinary use. Then, and only then will the duties of the Medical Committee cease and it will automatically stop functioning.

III. THE RED CROSS

In order to properly function as above, there must be a very definite and mutual understanding between the Medical Set-up and the Red Cross. In addition to the cots, blankets, etc., mentioned before, the medical men will need the following:

A. Adequate equipment:

1. Emergency surgical kits.
2. Needles and syringes.
3. Dressings and bandages.
4. Splints and tourniquets.
5. Germicidal agents.
6. Intra-venous sets.
7. Transfusion sets.

Note: We realize that it is almost impossible to adequately supply each team with all the above; but we believe that one or more central depots should be established in Elizabeth, in three fire houses, by the Red Cross, where this all-important equipment might be stored and become available not within a few days, nor even within several hours, but *immediately* at the time of disaster.

B. A properly trained civilian corps, whose duty it shall be to drive ambulances, act as stretcher-bearers and clerks (to properly fill out the aforementioned tags, etc.), and to assist generally the medical attendant.

C. An adequate supply of nurses to serve the Reception Centers and overflow stations.

D. A central joint headquarters for the Red Cross officer and the Medical Director.

IV. THE POLICE AND TRANSPORTATION COMMITTEES

Doctors going to and from the disaster should be given a suitable sign or insignia, and the right of way through the streets and highways.

Note: Within a very short time after the Kenvil disaster, the roads leading to and from

Kenvil were completely and hopelessly jammed by anxious relatives, curiosity-seekers, and travelers.

Unless all roads leading to or from the scene of disaster are kept open, and doctors, nurses, and ambulance drivers are given the "go" sign, the maximum efficiency cannot be attained.

R. M. NITTOLI, M.D., Chairman,
Medical Preparedness Committee,
Union County.

Return your A. M. A. Questionnaire on Medical Preparedness today.

POST-GRADUATE COURSES

A post-graduate course in diseases of the liver and biliary tract at Newark City Hospital is announced by the New York University College of Medicine. This brings to four the total number of courses being given at Newark City Hospital under the sponsorship of the University during the academic year.

The courses are:

Peripheral Vascular Diseases, January 15, through February 14, 1941.

Diseases of the Liver and Biliary Tract, February 25, through March 27, 1941.

Fractures, February 5, through April 2, 1941.

Amputations, March 1, through April 12, 1941.

To the limits of the course quotas, all the courses, except that in amputations, are open to general practitioners.

The course in peripheral vascular diseases, which is held on Wednesday and Friday afternoons from 3:30 to 5:30 o'clock for five consecutive weeks, is being repeated at the request of a number of physicians. The sessions are devoted to lectures, practical demonstration of cases, and operative clinics at the City Hospital and the Presbyterian Hospital of Newark.

Post-graduate study in fractures will cover the treatment of all fractures except those of

the head. Sessions will be held on consecutive Wednesday mornings, from nine o'clock to noon, during the nine-week period.

The work in diseases of the liver and biliary tract will comprise a comprehensive review of these diseases, designed to familiarize the general practitioner with the recent advances in diagnosis and treatment. The hours are nine to ten o'clock Tuesday and Thursday mornings, for five weeks.

Fellows of the American College of Surgeons, and Diplomates of the American Board of Surgery, are eligible for admission to the post-graduate course in amputations. Recent advances in the surgical treatment and the after-treatment of amputations will be presented during the seven Saturday morning sessions.

Additional details concerning the courses and applications may be obtained by writing to the Office of the Dean, New York University College of Medicine, 477 First Avenue, New York, N. Y. Information about other post-graduate and graduate courses offered by the College of Medicine may also be secured from the same source.

STUART HAWKES, Chairman,
Committee on Post-Graduate Education.

NEW YORK ACADEMY OF MEDICINE

A course of five lectures on obstetrics for general practitioners will be given from January 8 to February 5, inclusive, in the Academy Building, 2 East 103rd Street, New York

City, on Wednesday afternoons at 4:30 o'clock. The lectures will be eminently practical, and are free and open to all practitioners of medicine.

GRADUATE COURSE IN FRACTURES

The Newark City Hospital has announced the establishment of a post-graduate course in fractures under the sponsorship of the New York University College of Medicine. Sessions will be held on Wednesday mornings from nine to twelve o'clock for the nine-week period February 5 through April 2, 1941.

During this period the diagnosis and treatment of all types of fractures except those of the head will be presented with practical demonstrations of reductions on patients whenever

possible. There will also be demonstrations of the use of special apparatus, of anesthesia, applications of plaster dressings, and after-care. Ward rounds on the surgical services will be made as part of the course.

The course will be directed by Dr. Herbert A. Schulte, of Newark City Hospital. Requests for information regarding this and other post-graduate courses should, however, be directed to the office of the Dean, New York University College of Medicine, 477 First Avenue, New York, N. Y.

POST-GRADUATE COURSE IN AMPUTATIONS

A post-graduate course in amputations at Newark City Hospital is announced by the New York University College of Medicine. Sessions will be held Saturday mornings, 9 to 11 o'clock, from March 1 until April 12. This is the third new course at Newark City Hospital to be offered this year under the sponsorship of the university. The others are the course in peripheral vascular diseases, which ends the first week in December; and the course in fractures, which will be held on Wednesday mornings from February fifth through April second.

The post-graduate course in amputations will be directed by Dr. Henry H. Kessler, of the Staff of Newark City Hospital. This course is open only to Diplomates of the American Board of Surgery and to Fellows of the American College of Surgeons, but is not limited to men from New Jersey.

The aim of the course is to present recent ad-

vances in the surgical treatment and after-treatment of amputations. There will be six lectures, practical demonstrations, and some cadaver work. The phases of the work covered will include historical and statistical considerations, indications for amputations, sites of election, both classical and newer operative technics, complications and plastic revisions of amputation stumps, and cineplastic operations. Particular attention will be given to prosthetic appliances. Application of artificial limbs to both upper and lower extremities will be demonstrated by the use of extensive material from the New Jersey Rehabilitation Commission.

Detailed descriptions and applications may be obtained from the Office of the Dean, New York University College of Medicine, 477 First Avenue, New York, N. Y. Information concerning other post-graduate and graduate courses offered by the College may also be secured from the same office.

BULLETINS OF COUNTY SOCIETIES

Sixteen County Medical Societies of New Jersey publish bulletins, most of them being monthlies. These are valuable sources of information and inspiration. The list of bulletins and their editors is as follows:

Atlantic—Dr. Walter B. Stewart, 8 N. Tallahassee Ave., Atlantic City

Bergen—Mr. F. Edw. Whitehead, 770 Bogert Road, River Edge

Burlington—Dr. E. W. Rodman, 503 Cooper St., Beverly (Secretary)

Camden—Dr. G. B. German, 429 Cooper St., Camden (Secretary)

Cape May—Dr. Clarence W. Way, Sea Isle City

Cumberland—Dr. F. Muriel Ramsey, 310 E. Pine St., Millville (Secretary)

Essex—Dr. Henry A. Davidson, 31 Lincoln Park, Newark

Gloucester—Dr. Chester I. Ulmer, Gibbstown (Secretary)

Hudson—Dr. Nicholas M. Alter, 410 Fairmount Ave., Jersey City

Hunterdon—No Bulletin

Mercer—Dr. A. D. Hutchinson, 913 W. State St., Trenton (Secretary)

Middlesex—Dr. Edw. F. Klein, 136 Market St., Perth Amboy

Monmouth—Dr. W. Fred Jamison, 501 Grand Ave., Asbury Park (Secretary)

Morris—Dr. George J. Young, 60 Maple Ave., Morristown (Secretary)

Ocean—No Bulletin

Passaic—Dr. Joseph E. Mott, 426 Park Ave., Passaic

Salem—No Bulletin

Somerset—No Bulletin

Sussex—Dr. Jesse McCall, 12 Church St., Newton

(Secretary)

Union—Dr. K. Falconer, 1137 East Jersey St., Elizabeth (Executive Secretary)

Warren—No Bulletin.

THE STATE SOCIETY AWARD, 1941

The Medical Society of New Jersey has authorized an award of one hundred dollars for the best essay on an original medical subject, submitted according to the following rules:

1. Any medical or surgical subject may be selected.
2. The essay must be unpublished and of interest to the general practitioner.
3. Contributions must come from members of the Society who are in good standing.
4. The manuscript must not exceed 5000 words; and shall be typewritten in English, in manuscript form, with double spacing, wide margins and be

written on one side of the page, and five copies shall be submitted.

5. Manuscripts must be in the office of the Secretary of the State Society, Dr. Alfred Stahl, 55 Lincoln Park, Newark, N. J., not later than April 15, 1941.

6. The winner shall be determined by a secret Awards Committee composed of five members of The Medical Society of New Jersey. The officers of the State Society are not eligible for the award.

7. The winner shall be awarded a cash prize of \$100; and an invitation to present the contribution before the 1941 Annual Meeting of the State Society.

8. The Society reserves the right to make *no award*, if in the judgment of the committee no contribution is desirable.

WELFARE COUNCIL OF NEW JERSEY

The New Jersey Welfare Council,—formerly the Council of Social Workers,—held its annual meeting on December 5, 6, and 7, in the Berkeley-Carteret Hotel, Asbury Park, with over one thousand participants. The theme of the program was "The Cost of Government as Related to Welfare Problems".

The conference was opened Thursday evening, and was led by Dr. J. Douglas Brown, Ph.D., Professor of Economics of Princeton University, with an address on "Costs of Government".

On Friday morning there was a general session, consisting of a panel discussion, with the following participants:

Health, Dr. S. T. Snedecor, Past President, The Medical Society of New Jersey
Juvenile Delinquency, Dr. Douglas H. McNeill, State Juvenile Delinquency Commission

Relief, William J. Ellis, Commissioner, State Department of Institutions and Agencies

Vocational Education, John A. McCarthy, Assistant Commissioner of Education of New Jersey

The discussions were closed with a general question-and-answer period.

Friday afternoon was occupied with twenty-three special groups discussing social problems.

In the evening a dinner meeting was held, at which reports were made by five committee chairmen; also an address was given by Bailey B. Burritt, Chairman, Community Service Society of New York, on the subject "Social Work in a Troubled World".

On Saturday morning a "Town Meeting" was held, and a summary of the conference was given by Dr. Ellen C. Potter, Director of Medicine, State Department of Institutions and Agencies.

PHYSICAL THERAPY PHYSICIANS ORGANIZE

Announcement is made of the formation of the New Jersey Society of Physical Therapy Physicians, on November 13, 1940, at the Academy of Medicine of Northern New Jersey. Officers elected for the ensuing year were: Jerome H. Samuel, M.D., of Newark, as President; Eugene G. Charbonneau, of East Orange, as Vice-President; Michael J. O'Connor, of Newark, as Treasurer; and Robert F. Dow, of Paterson, as Secretary.

Dr. B. S. Troedsson, of Orange, was appointed Chairman of the Program Committee, assisted by Drs. Richard Coe and Eugene Charbonneau.

It was decided to hold meetings monthly during the Winter season in variable centers in the State. The next meeting will take place in January, in Essex County. Details will be announced later.

ROBERT F. DOW, Secretary.

MEDICAL DIRECTORY

The Medical Directory of New York, New Jersey, and Connecticut will be published during the year 1941 by the New York Society on its own responsibility. The New York Society will collect the data in New Jersey by means of a post card addressed to each individual member, and containing a copy of the information which was printed in the 1939-1940 edition.

Listing in the directory will be to the personal advantage of each physician in New Jersey. Therefore, please correct or complete the reply card, and mail it as soon as you receive it.

ARE VITAMINS FOODS, OR DRUGS?

The Board of Pharmacy of the State of New Jersey announces that there has been no change in its classification of vitamin products under the Pharmacy Act of this State. The Board holds that vitamin capsules and preparations of vitamins are drugs or medicines within the meaning of the Pharmacy Act when they are dispensed in concentrated dosage forms, and labeled with directions for use in the diagnosis, cure, mitigation, treatment or prevention of disease in man or animals; and therefore the sale of such products is restricted to Registered Pharmacists, or persons working under the supervision of Registered Pharmacists.

The Board has been advised by Assistant Attorney-General Bruther, who is its legal adviser, that the dismissal of the complaint filed by the Board of Pharmacy of the State of New Jersey against a department store involving the sale of "Vitamin Plus" without the supervision of a registered pharmacist, affects only this product. It has been erroneously reported in the press that Judge Davidson of the Passaic County Court of Common Pleas has held that vitamins and vitamin products are foods, and not drugs, and that their sale is, therefore, not amenable to the Pharmacy Act.

The only question for decision before Judge Davidson was whether or not the product "Vitamins Plus" is a drug or medicine within the meaning of the Pharmacy Act, and his decision in his own words reads as follows: "My conclusion is that 'Vitamins Plus', whether called an accessory food factor, or a dietary supplement, is still essentially a food product; and the complaint, therefore, should be dismissed."

Until the Supreme Court of the State of New Jersey has passed upon the appeal which the Board of Pharmacy is expected to file in this case, the decision cannot be considered final. In any case, however, the Court decision affects only "Vitamins Plus", and does not affect other vitamin products.

It is anticipated that actions against other vitamin products will be prosecuted by the Board of Pharmacy of the State of New Jersey in the near future.

MEDICAL SERVICE IN CHINA

The following note has been received from the Medical Department, Methodist Board of Foreign Missions, 150 Fifth Avenue, New York City, regarding the experience of Dr. S. H. Liljestrand, M.D., a native of Onondago County, New York, and a graduate of Syracuse University Medical School in 1915. For over twenty years he has conducted the Woman's Hospital connected with West China University, which was completely destroyed in a fire which followed a Japanese air raid in August. Dr. Liljestrand writes as follows:

The fire which destroyed the Women's Hospital destroyed all of my cystoscopic and electrotherapeutic apparatus and the accessories of a general gynecological clinic. Fortunately I had loaned a cystoscope to the Men's Hospital a block away. Also, the radium was saved, being in a patient that night. The patient was ambulatory. She went to a Chinese hospital because of the fire. In the morning, her honorable husband informed us of her whereabouts and the radium was recovered! I still have only fifty milligrams—but that is a mighty help.

I lost a diathermy machine; an ultra-violet lamp, large size; three adult-size cystoscopes; one infant's and one children's cystoscope galvanic electrical apparatus.

The fire also destroyed our medical periodicals—including those on urology, surgery, gynecology, and obstetrics. * * *

I would be very glad if we could get second-hand apparatus and used copies of medical magazines. * * * There continues to be great demand for our services in this war-torn section of China.

The letter from the Missionary Society closes with the following appeal:

If any of your readers are interesting in assisting Dr. Liljestrand with used but good-conditioned material, will they please communicate with the Medical Department, Board of Foreign Missions, Methodist Church, 150 Fifth Avenue, New York City.

OBITUARIES

DR. B. M. HOWLEY

Dr. B. M. Howley, of New Brunswick, nose and throat specialist, died on September 2, 1940, in St. Peter's Hospital, New Brunswick, from cerebral hemorrhage.

Dr. Howley was born in Scotland on June 15, 1871, and graduated from the New York University Medical College in 1894. He served his internship in the Manhattan Eye and Ear Hospital, and became Chief of Staff in St. Peter's and Middlesex Hospitals. He was active in the State and County Medical Societies, and in the Knights of Columbus.

DR. THEODORE J. MILLER

Dr. Theodore J. Miller died from malignant endocarditis on September 5, 1940, in his home in Perth Amboy, aged thirty-one years. He was born on February 28, 1909, in Perth Amboy. He graduated from Rutgers University in 1930, and from the Long Island College of Medicine in 1934. He interned in the Elizabeth General Hospital, and opened an office in Fords, Middlesex County. He was on the Staff of the Perth Amboy General Hospital, and was a member of the Middlesex County Medical Society and took an active part in public health affairs.

DR. FRANK H. WARNCKE

Dr. Frank H. Warncke, of Elizabeth, N. J., died on December 26, 1940, from aortic aneurism, aged 59 years. He was born in Brooklyn, N. Y., and graduated from the New York University Medical School in 1904. He served as interne in St. Joseph's Hospital, Paterson, and in the General Hospital of Elizabeth. He spent the remainder of his life in general practice in Elizabeth, except that for the years 1908 and 1909 he was physician to a mining company in Mexico.



Dr. Warncke was a member of the Staff of the Elizabeth General Hospital, and for twenty-eight years he was chief physician to the Public Service Corporation of the City of Elizabeth. He was an active member of the Union County Medical Society, The Medical Society of New Jersey, and the American Medical Association.

Resolutions of respect were adopted by the Union County Medical Society, the Medical Board of the Elizabeth General Hospital, and the St. Elizabeth Hospital.

DECEASED PHYSICIANS — NEW JERSEY

Data supplied by the State Department of Health

Name	Age	Date of Death	Place of Death	Residence	Cause of Death
Theodore B. Fulper	73	Nov. 15, 1940	Hampton	Same	Uremia.
Ernest H. McDede	60	Nov. 30, 1940	Kearny	Lyndhurst	Myocarditis.
William S. MacLaren	74	Nov. 29, 1940	Princeton	Same	Myocarditis.
Norman Rowe	64	Nov. 29, 1940	Jersey City	Same	Carcinoma.

NUMBER OF CHILDREN REPORTED RECEIVING FREE STATE BIOLOGICALS
SINCE JULY 1, 1940

DIPHtheria TOXOID					SMALLPOX VACCINE				
County	Total to Oct. 31	Month of Nov.	Total to Nov. 30	Average per Month	County	Total to Oct. 31	Month of Nov.	Total to Nov. 30	Average per Month
Atlantic	6019	760	6779	1355.8	Atlantic	485	78	563	112.6
Bergen	782	345	1127	225.4	Bergen	800	111	911	182.2
Burlington	84	1	85	17.	Burlington	189	27	216	43.2
Camden	677	7	684	136.8	Camden	1139	52	1191	238.2
Cape May	17	1	18	3.6	Cape May	40	1	41	8.2
Cumberland	53	7	62	12.2	Cumberland	118	4	122	24.4
Essex	3229	762	3991	798.2	Essex	2903	596	3499	699.8
Cumberland	53	9	62	12.2	Gloucester	181	11	192	38.4
Hudson	531	286	817	163.4	Hudson	1832	64	1896	379.2
Hunterdon	4	5	9	1.8	Hunterdon	20	0	20	4.
Mercer	495	372	867	173.4	Mercer	605	208	813	162.6
Middlesex	53	285	338	67.6	Middlesex	270	302	572	114.4
Monmouth	849	67	916	183.2	Monmouth	320	23	343	68.6
Morris	292	68	360	72.	Morris	341	103	444	88.8
Ocean	14	1	15	3.	Ocean	11	0	11	2.2
Passaic	1858	771	2629	525.8	Passaic	1451	298	1749	349.2
Salem	157	14	171	34.2	Salem	210	22	232	46.4
Somerset	157	9	166	33.2	Somerset	113	7	120	24.
Sussex	0	1	1	.2	Sussex	3	18	21	4.2
Union	908	125	1033	206.6	Union	944	59	1003	200.6
Warren	43	4	47	9.4	Warren	173	12	185	37.
Totals	16274	3901	20175	4035.	Totals	12148	1996	14144	2828.8

COUNTY SOCIETY REPORTS

COUNTY SOCIETY COMING MEETINGS

JANUARY, 1941

7 Camden	14 Bergen
7 Hudson	14 Cape May
8 Mercer	15 Middlesex
8 Ocean	16 Gloucester
8 Union	16 Morris
9 Burlington	17 Salem
9 Essex	21 Warren
9 Passaic	22 Monmouth
9 Somerset	28 Hunterdon
10 Atlantic	

FEBRUARY, 1941

4 Camden	13 Essex
4 Hudson	13 Passaic
11 Bergen	13 Somerset
11 Cape May	14 Atlantic
11 Cumberland	19 Middlesex
12 Mercer	20 Gloucester
12 Ocean	21 Salem
13 Burlington	26 Monmouth

ATLANTIC COUNTY

Charles Hyman, M.D., Reporter

The regular monthly meeting of the *Atlantic County Medical Society* was held December 13, 1940, at the Ambassador Hotel, Atlantic City. The meeting was called to order by the President, Dr. V. Earl Johnson, at 9 p.m.

SCIENTIFIC

Dr. R. Franklin Carter, Associate Clinical Professor of Surgery, New York Post-Graduate Medical School, Columbia University, New York City, spoke on the "Selection of Gall-Bladder Patients for Surgical Treatment, and Their Postoperative Care". Dr. Carter very clearly brought out the importance of proper preoperative study and preparation before the case is brought to surgery. No generalizations can be made as to which type of case is best suited for surgery, or which will get the perfect result. Certainly the most general statement that can be made is that cases with stones should be operated, and only to remove the stones as a possible factor in obstruction to the ducts at a later date, and not with the view of promising that the operation will cure the gall-bladder disease. The medical management of the operated case is important in the final result. Although the operation can or does cure the mechanical factors involved, the biliary dyskinesia still needs intelligent medical treatment.

The paper was discussed by Drs. Read and Allan.

RELATION TO THE STATE SOCIETY

Dr. LeRoy Wilkes, Executive Officer of the State Society, addressed the Society on the relationship between the executive offices and the State Society program.

BURLINGTON COUNTY

Reported by T. Bruce Dickson, M.D.

The monthly meeting of the *Burlington County Medical Society* was held on November 14, at Moorestown, with forty-one members present. This was the one hundred and eleventh anniversary meeting of the County Society, having been instituted on May 19, 1829, by Drs. Nathan Cole, John

L. Stratton, John C. Davis, Charles Ellis, and Benjamin H. Stratton (Transactions of State Society, Vol. 1, page 249).

SCIENTIFIC

Dr. Herbert T. Kelly, of Philadelphia, gave a very interesting talk entitled "The Present Status of Deficiency Disease, with Special Reference to Vitamin Therapy".

MEMBERSHIP

Dr. Joseph Newmeyer, of Delanco, was elected a member of the Burlington County Medical Society by transfer from the Camden County Medical Society by a letter from the Secretary, Dr. George B. German.

CAMDEN COUNTY

Harold D. Barnshaw, M.D., Reporter

The regular meeting of the *Camden County Medical Society* was held in the City Dispensary Building, on November 5, 1940, with the President, Dr. Robert S. Gamon, presiding.

SCIENTIFIC

The scientific address was delivered by Dr. Edward A. Strecker on the subject "Alcoholism".

MEMBERSHIP

Dr. Sidney Friedenber, recently elected member, took the oath of membership and was introduced to the Society.

The following were elected to active membership:

George Garrison, Cooper Hospital, Camden
William Snagg, Camden
Jacob Drossner, Camden
Louis Riegert, W. Collingswood
Thomas Hughes, Camden
Edward Platt, Haddon Heights
H. A. Pinsky, Camden

EMERGENCY RELIEF PLAN

Dr. Sharp, Chairman of the Executive Committee, explained the new Emergency Relief Plan. On motion by Dr. Decker, the plan was approved.

MEDICAL PREPAREDNESS

Dr. Decker reported that the confusion in the choice of the personnel of draft boards had been cleared up by the decision of the Adjutant General to appoint only those physicians who were approved as experts by the Medical Society.

CAPE MAY COUNTY

Clarence W. Way, M.D., Reporter

A regular meeting of the *Cape May Medical Society* was held on Tuesday evening at 9 o'clock, December 10, 1940, at the Bellevue Hotel, Cape May Court House, N. J.

SCIENTIFIC

Dr. Willets P. Haines, Ocean City, addressed our society on "Medical Preparedness", and explained the forms on which the records of the examination of recruits are to be made. He presented D. S. S. Form 200 Report of Physical Examination and explained it in detail. He referred back to the last World War, citing the fact that many mistakes occurred then by which the medical profession may profit now.

Drs. H. H. Hornstine, Samuel S. Gidding, George F. Dandois, all of Wildwood, and Dr. Millard Cryder, of Cape May Court House, and Dr. C. W. Way, of Sea Isle City, participated in the discussion.

Major C. W. Way, Medical Reserve Corps, United States Army, said: "The first essential of a nation purposed to defend itself is physical, mental, and moral health. There will be a contingent of 5300 doctors to be called up early next year, bringing the Medical Corps to 9100. Physicians in the Reserve Corps will be given at least two weeks' notice so they can dispose of their professional affairs. Our County Medical Society, preparing for mobilization of its members, has asked all members who take over the practice of those called up, to share the fees fifty-fifty with the absent physicians. After they return the patients are to be sent back to them."

A letter of appreciation was read from Assemblyman John E. Boswell.

HOSPITAL STAFFS

Dr. Aldrich C. Crowe, President of the Cape May County Medical Society, has been elected President of the Medical Staff of Atlantic Shores Hospital, Somers Point, N. J., and Dr. C. Paul Cameron, Ocean City, N. J., has been chosen the Vice-President for the coming year.

CUMBERLAND COUNTY

E. C. Lyon, M.D., Reporter

The December meeting of the *Cumberland County Medical Society* was held in the Cumberland Hotel, Tuesday, December 10th, 1940, at 2:30 p. m.

MEMBERSHIP

Dr. Albert B. Kump, of Bridgeton, was unanimously elected into full membership.

PRESERVATION OF RECORDS

Dr. M. F. Sewall reported that a safe depository for the historical county medical records had been acquired.

TUMOR CLINICS

Dr. Charles E. Sharp discussed the activities of the three tumor clinics held in the county. He was authorized to plan a post-graduate course of lectures to be held in the Spring.

Dr. Norman Scott, Assistant Executive Officer of the New Jersey State Medical Society, described in detail the "Medical Service Administration of New Jersey". He stated it was a non-profit corporation, formed to assist selected groups of persons in securing medical and surgical services. After a lengthy discussion the County Society endorsed the work as presented.

ESSEX COUNTY

Paul H. Hosp, M.D., Reporter

The regular monthly meeting of the *Essex County Medical Society* was held on December 12, 1940, at the Academy of Medicine in Newark. President Harry Comando called the meeting to order promptly at nine o'clock.

ADMINISTRATIVE

Dr. LeRoy A. Wilkes, Executive Officer, gave an address on "The Functions of the Executive Office of the State Medical Society".

SCIENTIFIC

Dr. Comando turned over the meeting to Dr. Chester R. Brown, Chairman of the Child Welfare Committee. After a few remarks pertaining to infant mortality and upon the wonderful work in reducing this mortality in Essex County, Dr. Brown introduced the speaker of the evening, Dr. Oliver L. Stringfield, Assistant Professor of Pediatrics, Columbia University, who gave an illustrated talk on the subject "Factors Affecting Mortality Rates Among Premature Infants".

Dr. Stringfield started out by saying there must be 100 per cent coöperation between the obstetrician, the pediatrician, the hospital, and the parent, if the mortality rate among prematures is to be reduced. He emphasized birth points to remember about prematures,—that they are immature in four of their bodily systems:

1. The respiratory.
2. The circulatory.
3. The heat regulating.
4. The digestive.

The mortality rate of prematures in 1932 in the United States was 50 per cent. In 1933 it was 46 per cent.

In New Jersey in 1932 it was 47.3 per cent, while in 1933 it was 38 per cent.

He stated that the Boston Lying-In Hospital has the ideal set-up to take care of premature babies. A pediatrician is in charge of the child as soon as it is born.

Premature babies born by Cesarean section have practically the same death rate. The anesthesia and drugs administered to the mother have a bad effect upon the child. Analgesics and morphine administered to the mother during labor may be all right where there is a full-time pregnancy; but this is not so in premature births.

The speaker said the ideal ways to reduce the premature death rate are:

1. Coöperation between the obstetrician, the pediatrician, the hospital, and the parent.
2. Reorganize the pediatric equipment,—incubator, beds, etc.
3. Treat each case as an emergency; and make use of the services of a pediatrician.
4. Use obstetrical anaesthesia and analgesia to only a minimum degree.
5. Further necessary points are:
 - a. Stabilizing the temperature of the child.
 - b. Nutrition properly administered.
 - c. Prevention of infection.
 - d. Nursing and medical care properly given.

EXHIBIT ON FACILITIES AND METHODS

There was an excellent exhibit by the St. James' Hospital Children's Department, under the supervision of Dr. Harold Murray. Incubators, heated cribs, proper beds, feeding and clothing necessary for the premature were shown in the lobby of the Academy of Medicine.

EXHIBIT ON THE CLINICAL LABORATORY

Here is something that you must not miss.

The exhibit called "How the Clinical Laboratory Fights Disease" is now shown at the Newark Museum, Newark. Miss Beatrice Winsor, Museum Head, offered to the County Society the space for the exhibit. The actual material was assembled by Dr. Extron of the Prudential Insurance Company, and Dr. S. Berg of Newark, in collaboration with Dr. Ben Saslow, Chairman of Exhibits of the County Society.

The Exhibit shows important subdivisions of the clinical laboratory. For one hour each afternoon technicians demonstrate various procedures. A viewing microscope shows six slides at a time, with suitable cards explaining each slide. The exhibit is open to the public and is well attended.

REFRESHER COURSES

The refresher courses given by the Essex County Society in conjunction with New York University are surely in demand. There will be a repeat of the one covering vascular diseases. This course was given last Fall, and was over-subscribed. It will be repeated about the middle of January.

A course covering amputations is scheduled for February.

MEMBERSHIP

New members were elected as follows:

Active:

John H. Donnelly, Newark

Associate:

Jules E. Baime, Newark
Louis Bender, Newark
E. P. Duffy, Jr., Belleville
Henry L. Kuperman, Newark
George Rigeron, Bloomfield
Mortimer L. Schwartz, Newark

GLOUCESTER COUNTY

C. A. Bowersox, M.D., Reporter

The monthly meeting of the *Gloucester County Medical Society* was held in the Woodbury Country Club on December 19, 1940, Dr. Henry Diverty, President, presiding.

MEMBERSHIP

Dr. Henry Whitaker, of Pitman, was elected a member of the Society.

MEDICAL PREPAREDNESS

Dr. William Pedrick, of Glassboro, described the special meeting of the Defense Commission at Trenton. He emphasized the need that everyone in this society answer his A. M. A. questionnaire.

FIFTH COUNCILOR DISTRICT

Dr. Chester I. Ulmer, of Gibbstown, then took charge of the meeting as Councilor of the Fifth Councilor District of New Jersey, and introduced the Presidents of the different societies in this district.

Dr. Thomas K. Lewis, of Camden, President-Elect of The Medical Society of New Jersey, emphasized the need of coöperation of the various members of the New Jersey Societies with the American Medical Association. He also said that special effort should be made to complete the recent questionnaire in order to facilitate the defense work at Trenton. He also stated that 100 per cent of the members offered their services to induction boards.

ADDRESS BY DR. F. H. LAHEY

Dr. Chester I. Ulmer then introduced the speaker of the evening, Dr. Frank H. Lahey, of the Lahey Clinic, and President-Elect of the American Medical Association, who talked on the "Management of Diseases of the Thyroid Gland". He stated that there had been 90,700 thyroidectomies at the Lahey Clinic, and that the mortality rate was .76 of one per cent. Carcinoma of the thyroid gland occurs in benign tumors of the gland in 96 per cent of all cases. It is important that all tumors be removed regardless of size, in order to prevent any malignant change. In these cases radical operations should always be done, and radiation given if necessary, especially in cases where both lobes are involved. Blood chlorestrol is coming to be one way of determining the degree of hypo-thyroidism taken in addition to the basal metabolic rate. Chlorestrol is easily metabolized, and is, therefore, high in hypothyroidism. Emboli are quite common in hyperthyroidism, but there is no effect upon the heart muscle. Death usually occurs as a result of em-

boli, and not of immediate heart failure. The blood iodine drops to normal in 70 per cent of all cases following thyroid removal. In all cases oxygen and intravenous glucose are given pre-operatively. This is to overcome the poor liver function present, and the defect in oxygen consumption.

HUDSON COUNTY

John N. Connell, M.D., Reporter

A regular meeting of the *Hudson County Medical Society* was held on Tuesday, November 3, 1940, in the Masonic Club, Jersey City. The President, Dr. George Ginsberg, called the meeting to order at 9:15 p. m.

MEMBERSHIP

The following physicians were elected to membership:

Francis L. Boyle, Bayonne
Kenneth Judy, Bayonne
John W. Kennedy, Weehawken
C. P. McCarthy, Bayonne

Dr. Morris Grossman, Jersey City, was admitted by transfer from the Medical Society of New York County.

Five physicians were proposed for membership.

SCIENTIFIC

Dr. Elliott P. Joslin, Clinical Professor of Medicine, Emeritus, Harvard University, gave an address on "The Renaissance of the Treatment of Diabetes". The subject was discussed by Drs. G. Ginsberg, J. W. Fineberg, A. E. Jaffin, C. Sirken, T. White, and M. Bresov.

NOMINATION FOR STATE OFFICE

On motion of Dr. A. J. Conty, seconded by Dr. W. L. Williamson, the society voted to propose and support Dr. Joseph F. Londrigan for the office of Second Vice-President of The Medical Society of New Jersey.

MIDDLESEX COUNTY

J. J. Jablonski, M.D., Reporter

The regular meeting of the *Middlesex County Medical Society* was held at the Roosevelt Hospital, Metuchen, on Wednesday evening, November 20, 1940, with about 25 members of the Middlesex County Pharmaceutical Association as its guests. Dr. B. F. Slobodien, President, presided.

MEMBERSHIP

Dr. S. David Miller, New Brunswick, was elected to Associate Membership.

The following Associate members were elected to Regular membership:

William V. Gadek, Perth Amboy
Norman Reitman, New Brunswick
John A. Smith, South River

SCIENTIFIC

Dr. Richard A. Deno, Assistant Professor of Biological Sciences, Rutgers University, New Jersey College of Pharmacy, presented an interesting lecture on the Sulfonamide group of drugs.

Mr. J. J. McLaughlin, of Paterson, President of the New Jersey Pharmaceutical Association, spoke on the ways and means of better coöperation between the physician and the pharmacist. He stated that the new Formulary, and the fourth edition of the N. J. Formulary, will soon be ready.

Dr. Ernest Little, Dean of the N. J. College of Pharmacy, discussed the value of coöperation between the physician and pharmacist.

OBSTETRIC CONSULTANTS

Dr. Calvin discussed the situation in regard to obstetric consultants, and stated that any physician may fill out the required form and send it to Dr. Julius Levy of the State Health Department in Trenton, if he feels that he is qualified to participate on the consultant program for the county.

CHILD CARE

Dr. H. P. Fine discussed the film "When Bobby Goes to School", and recommended that this film be shown under the supervision of a physician.

Dr. Fine also reported that the Advisory Committee on Child Health of the State Medical Society offers to provide a speaker to discuss its plan for child care in the coming year. It was decided to accept this offer.

After the meeting was adjourned the members and guests were served refreshments in the Hospital Cafeteria.

The *Annual Dinner Meeting of the Middlesex County Medical Society* was held at the Roger Smith Hotel, New Brunswick, N. J., December 18, 1940, with more than one hundred members present. Dr. Slobodien, President, presided.

MEMBERSHIP

The following physicians were elected to associate membership:

Eli L. Cooperman, Fords
James J. Lucey, Perth Amboy
William Rubin, New Brunswick

The following associate members were elected to regular membership:

N. N. Forney, Jr., Milltown
E. H. Bergman, Milltown
C. E. Hesseltine, South Amboy

CRIME DETECTION

The speaker of the evening was John T. Madigan, of the Newark Field Division of the Federal Bureau of Investigation, whose subject was "The F.B.I. Fights Crime". Mr. Madigan described the function of the Bureau, and the "Crime Laboratory" in Washington, D. C. The Bureau is successful in over 97 per cent of its persecutions.

FINANCES

Dr. Marshall Smith rendered a financial report of the County Society's standing, stating it is in very excellent condition. However, he enjoined the Society to take appropriate action about delinquent dues and cash on hand.

NEW OFFICERS

The following officers were elected for 1941:

President: Ralph J. Faulkingham, New Brunswick, N. J.

Vice-President: Matthew F. Urbanski, Perth Amboy, N. J.

Secretary: William Edgar Sherman, New Brunswick, N. J.

Treasurer: George Kohut, Perth Amboy, N. J.

Reporter: Cyril I. Hutner, Woodbridge, N. J.

Delegates to the House of Delegates of the State Medical Society::

B. F. Slobodien, Perth Amboy, N. J.

John H. Rowland, New Brunswick, N. J.

Edward F. Klein, Perth Amboy, N. J.

Alternates:

William C. Wilentz, Perth Amboy, N. J.

Charles J. Sullivan, New Brunswick, N. J.

Harry J. White, Metuchen, N. J.

Delegate and Alternate to the State Medical Society Nominating Committee for 1941:

Delegate: B. F. Slobodien, Perth Amboy, N. J.

Alternate: John F. McGovern, New Brunswick, N. J.

A letter was received from the Hudson County Medical Society asking for endorsement of Dr. Londrigan's candidacy for Second Vice-President of The Medical Society of New Jersey. A motion was seconded and passed endorsing Dr. Londrigan's candidacy.

A motion was passed that members of the Middlesex County Medical Society who enter military service be exempt from paying their dues while in service, and that the County Society pay their State Society dues.

MONMOUTH COUNTY

Murray Woronoff, M.D., Reporter

The regular monthly meeting of the *Monmouth County Medical Society* was held on November 27, 1940, at 9 p.m., at the Hotel Molly Pitcher, Red Bank, N. J.

SCIENTIFIC

The speaker of the evening was Dr. George E. Daniels, whose subject was "Some Aspects of Psycho-Somatic Medicine". Dr. Daniels discussed some of the organic diseases in which there was a psychic component. Some of the diseases discussed were:

1. Ulcerative colitis.
2. Mucous colitis.
3. Peptic ulcer.
4. Essential hypertension.

The meeting was well attended, and an interesting discussion followed the paper of the evening.

OCEAN COUNTY

Raymond A. Taylor, M.D., Reporter

The *Ocean County Medical Society* held its monthly meeting at the Paul Kimball Hospital in Lakewood, on the evening of December 11th, 1940.

Dr. A. W. Bingham, Chairman of the Maternal Welfare Committee of The Medical Society of New Jersey, gave a discussion on maternal mortality and welfare. He stressed prenatal care as being the basis of good obstetrics, and urged early consultation on abnormal cases.

A short business meeting was held, during which Dr. Adolph Towbin reported on the November meeting of the Delegates to the State Medical Society held in Newark, N. J.

PASSAIC COUNTY

Irving Okin, M.D., Reporter

The regular monthly meeting of the *Passaic County Medical Society* was held on Thursday, December 12, at School Number 13, Paterson, President Frank W. Ash presiding, with a large attendance of members.

MEMBERSHIP

Dr. Floyd Fortuin, of Paterson, was elected to Associate membership.

Three applications for membership were received.

SCIENTIFIC

The scientific session was addressed by Dr. Richard B. Cattell, Surgeon at the Lahey Clinic, Boston, who spoke on "The Management of Thyroid Diseases". He gave a very interesting and thorough discussion of the subject.

SALEM COUNTY

L. C. Hummel, M.D., Reporter

On Friday, November 15th, the *Salem County Medical Society* held its regular monthly meeting at the DuPont Club in Pennsgrove, N. J.

MEDICAL PREPAREDNESS

A report by Dr. F. H. Church, Chairman of the Committee for Preparedness, disclosed that much work and planning had been accomplished toward the handling of any major emergency that might befall the people of our county.

Following the business meeting we were privileged to hear an extremely engaging and instructive talk by Dr. W. D. Stroud, of Philadelphia, on "The Relationships Between the Gall-Bladder and Coronary Disease". He amplified his topic by discussing arteriosclerosis and hypertension, and covered the subject in a most delightful and comprehensive manner. His paper was discussed by Drs. C. P. Lummis and H. F. Suter.

Following the meeting dinner was served at the club.

SUSSEX COUNTY

F. Herbert Lushear, M.D., Reporter

The annual Fall meeting of the *Sussex County Medical Society* was held October 29th, 1940, at The Cochran House, Newton. Drs. Longnecker, Eddy, Kirschner, Coleman, D. L. Spurgeon, C. E. Spurgeon, Braun, Hawke, Vermes, Schmidt, Spencer, Pellet, McCall, Burn, and Lushear attended. After dinner the meeting was called to order by Dr. Jesse McCall, President.

DEVELOPMENT OF ORGANIZED MEDICINE

Dr. LeRoy Wilkes, Executive Officer of The Medical Society of New Jersey, as guest speaker, gave a short talk on the development of organized medicine in New Jersey and the progress that has been made since the start of the movement in 1766. He also emphasized the value of organized medicine to the average practitioner; and outlined briefly some of the many services it renders him.

MEDICAL SERVICE ADMINISTRATION

Dr. Norman Scott, Executive Assistant of The Medical Society of New Jersey, spoke on the Medical Service Administration, and outlined the three tentative plans. A general discussion followed. The society unanimously approved in principle the Medical Service Administration Plan as outlined by Dr. Scott.

MEDICAL PREPAREDNESS

Dr. Lester Eddy brought up the subject of Medical Preparedness, and a general discussion followed.

COMMITTEE REPORTS

The several committees reported, and appropriate action was taken.

CONSTITUTION AND BY-LAWS

A motion from the floor was made and passed that Dr. Kirschner head a committee of his own choosing instructed to revise the by-laws and constitution of the society so as to make them conform with the modern State Society Constitution and By-Laws. The recommendation of this committee will be taken up at the next meeting.

The meeting adjourned at twelve-thirty.

UNION COUNTY

C. C. Carpenter, M.D., Reporter

A regular meeting of the *Union County Medical Society* was held in Rahway on the evening of November 13, 1940, at 9 o'clock, with the President, Dr. George Knauer, presiding.

OFFICIAL VISITOR

Dr. Thomas K. Lewis, Camden, official visitor from the State Society, explained the parts which the county societies would take in the Fall Clinical Conference, and the special meeting of the House of Delegates, both of which will take place in two weeks.

SCIENTIFIC

Dr. Arthur W. Bingham, Chairman of the Advisory Committee on Maternal Welfare of The Medical

Society of New Jersey, reviewed the fifteen maternal deaths in Union County reported during the year 1939; and called attention to the similarity of the figures to those of the State as a whole. He pointed out the routine measures for preventing maternal deaths in childbirth.

Dr. Bingham called special attention to county obstetrical conferences to be held by each County Maternal Welfare Committee. The major subject to be considered was the data collected by the Field Physician concerning each maternal death in the county. The plan of investigating each death was discussed favorably by Drs. Bensley, Crabtree, Davis, Kreutz, McGeary, and Murphy.

TUBERCULOSIS

A complaint was received from the Elizabeth General Hospital concerning the large number of patients asking for free x-rays of the chest. The authorized reply from the County Society was that patients should pay for x-rays in proportion to their income.

Several colored physicians requested permission to attend courses in the early diagnosis of tuberculosis. The present courses are open to all members of the Union County Medical Society, to which sixteen colored physicians belong (Journal, July, 1940, page 388).

A request for mass x-rays was received from several union labor organizations, each of whose members receive \$17 or \$18 per week. The proposition was referred to the Public Health Committee to be settled after a friendly conference with the unions and the local Tuberculosis League.

MONTHLY BULLETIN

The Publication Committee reported that the expense of publishing the monthly Bulletin of the Society during the past year was \$300; while the receipts from advertisements were \$534. The balance of \$234 represents a profit, to be added to the funds of the Society.

MEDICAL PREPAREDNESS

Dr. Nittoli, Chairman of the Medical Preparedness Committee, summarized the work which it had done in local preparedness to deal with major disasters, such as fires and explosions.

MEMBERSHIP

Five applications for membership were received. Eleven physicians were elected to membership as follows:

Paul B. Boyer, Summit
S. H. Brethwaite, Jr., Summit
M. A. Chodosh, Carteret
Harry Cohen, Roselle
K. R. Fourcher, Linden
F. M. Mastrianni, Union
E. J. O'Brien, Plainfield
W. A. Reiter, Summit
A. O. Seeler, Roselle
G. McK. Stevenson, Summit;

and also A. A. Barberio, Union, by transfer from the Kings County Medical Society, Brooklyn, N. Y.

SUMMIT MEDICAL SOCIETY

E. H. Macpherson, M.D., Secretary

The *Summit Medical Society* held its November meeting on Tuesday evening of the 26th, at the Nurses' Home of Overlook Hospital, with Dr. Johnston, the President, presiding. There were twenty-eight members and nine guests present.

Dr. Yale Kneeland, of the New York Presbyterian Hospital, spoke on "Chemotherapy, Its Present Status, Including Pneumonia Treatment". He described the present treatment with the newer drugs,—sulfapyridine and sulfathiazol, and illustrated his address with lantern slides.

Following the meeting a collation was served.

NORTHERN NEW JERSEY DERMATOLOGICAL SOCIETY

Cedric C. Carpenter, Secretary

A meeting of the *Northern New Jersey Dermatological Society* was held on Wednesday evening, November 20, 1940, at the Auditorium of the Academy of Medicine in Newark, with Dr. N. B. Heller presiding.

HERPES ZOSTER

There was a prolonged discussion on the topic of Herpes Zoster because of an unusual case presented by Dr. Irving Lehrman. The patient was a white man, about forty-eight years of age, who twelve days previously had developed a vesicular eruption on the right anterior chest wall. The lesions on the chest, during this time, had changed to gangrenous, closely grouped ulcers, and there was associated fever and general malaise. New pustular and vesicular lesions gradually spread over the thighs, arms and face. However, there was very little itching with this condition. Three years ago this man had been admitted to the Newark City Hospital with swelling of the inguinal glands. At that time a diagnosis was made, by biopsy, of Hodgkin's disease.

The members agreed with the diagnosis of gangrenous Herpes Zoster, with an associated varicella-like eruption.

It is of great interest to find the common association of gangrenous herpes with the lymphoblastomas. No reason has been presented for this, unless there might possibly be a virus etiology in both conditions. Considering other possible causes,

members stated they had seen zoster following spinal anaesthesia, the intravenous use of arsenicals, and occasionally, after vaccination. There is also a frequent association, by contact, with cases of chicken pox. However, the reverse relationship, of chicken pox appearing after contact with herpes zoster, is practically never seen.

LUPUS ERYTHEMATOSUS

Dr. Samuel Ravitz presented a man, forty years of age, who had been under continuous treatment for sixteen years. There was marked scarring over the nose, cheeks and ears. Once or twice he had developed malignancies in this scar tissue, and they had been removed. This individual had received injections of neoarsphenamine, bismuth, and gold, as well as many drugs by mouth, including sulfanilamide, which had been taken for many weeks.

The problem of what to do with early cases to prevent scarring, which is extremely disfiguring, was discussed. It was brought out that sulfanilamide might be tried in the early cases, but the fear of *photosensitization* produced by this drug, in a disease which is partially caused by photosensitization, caused some of the members to consider this to be irrational. However, the same drawback is found in the use of quinine and gold, which have been quite popular in the past. It was felt that it might be better to save the sulfanilamide in the event that strong treatment be needed, as it was the impression of the members that the second course of sulfanilamide was much more toxic to the patient and less effective in clearing up the condition. Certainly this seems to be true in pemphigus, where 50 per cent of the cases do not do well on the second course of this drug. Recently some of the members have been using high doses of nicotinic acid and have been obtaining marked, but temporary, improvement. It is possible that this vitamin should be used in conjunction with some other form of more permanent therapy, such as gold, bismuth, or germanin.

NEW MEMBERS

The following men were elected to membership: Dr. John J. MacDonald, of Jersey City; Dr. Irving Shapiro, of Newark; Dr. Joseph Kwint, of Plainfield; Dr. Ralph J. Doran, of Hoboken; and Dr. Samuel Fischer, of Paterson.

MEDICAL SERVICE ADMINISTRATION IS YOUR ORGANIZATION. IT MUST BE SUPPORTED BY YOU. SEND INQUIRIES TO THE EXECUTIVE OFFICE.

WOMAN'S AUXILIARY

PUBLIC RELATIONS AND THE WOMAN'S AUXILIARY

By MRS. DON AGARD EPLER, Chairman, Public Relations

Community work is the theme song today! But be sure your work is approved by your Advisory Board of Doctors before plunging into new projects in the name of the Auxiliary.

As your Public Relations Chairman, I believe very firmly that all members of the Auxiliary can find a niche in their individual County Public Relations Committee; for here is the field in which we can do our best work.

CONTACTS WITH LAY GROUPS

One function of the Auxiliary is to develop more trained observers,—women capable of reporting to the Auxiliary President the reaction of mixed groups to the Medical Society.

The Auxiliaries are the doorways into lay groups; women's organizations are knocking at these doorways asking for guidance. The Medical Society is waiting to be invited in as the instructor. The Public Relations Committee is the link between them. Let it not be a missing link in any county in New Jersey.

SPEAKERS

The Public Relations Committee of The Medical Society of New Jersey is ready to supply speakers, medical exhibits (posters 24 or 30 inches square), movies on almost any health subject; and speeches or material which your local doctors are welcome to use in their lectures. The doctors do this, not for personal gain, but because they feel they owe it to a public that is in quest of authentic health information.

Busy physicians cannot give all their attention to the promulgation and the defense of truth. They need help. Where can they find it? The answer is, in those who believe in them, and who are willing to follow their leadership.

Doctors' wives share the lives of the physicians and understand their labors and sacrifices. Is it not natural that they should cooperate to carry out the aims of the profession?

We, as aides to these leaders, should understand this and should remember that our manifold contacts with other organizations is our most valuable service to the Medical Society.

Ours is the responsibility of keeping in mind always the public relations functions of the

Auxiliary. To promote better understanding between the Medical Society and the public requires a thorough knowledge of the current views on the subject, and a never-ending effort of self-education.

HEALTH EDUCATION

The Auxiliary's sphere of activity is great; in many special fields we may expend effort with most gratifying results. One such area is education; and here again is meant education not only of others, but also of ourselves. Knowledge is power, and if the Auxiliary is to accomplish its goal, its members must cultivate this power.

The public has become distinctly "health conscious", and with this new interest it has developed much unwarranted criticism of the profession, rooted in misinformation.

The next step after self-education is the education of the public. The doctor's wife, equipped with facts, is in a position to sow the seed of education whenever and wherever the occasion arises. Every member of the Auxiliary belongs to many lay groups such as Parent-Teacher Associations, Women's Clubs, and Church Groups. No organization is too small in size or too narrow in purpose for public relations work by Auxiliary members.

RADIO PROGRAM OF A. M. A.

Again this year the Auxiliaries were asked to cooperate with the Public Relations Committee of the Medical Society in publicizing the A. M. A. Radio Program, "Doctors at Work", every Wednesday evening at 10:30 p. m. over WJZ (Blue Network).

Let us place a radio poster in every doctor's waiting room, woman's club, library, high school lobby, bus and railway station, beauty parlor, and any other place where people congregate. The Auxiliary can do much to keep these radio programs before the public.

We want to do our part in turning popular thought strongly in the direction of ethical organized medicine, and away from the charlatans and cults pervading the country. As members of the Auxiliary, let us carry forward the banner of truth through our personal contacts.

"Success is achieved by doing things now."

COMING EVENTS

Atlantic County

January 10, 1941, 9:00 p. m.

Speaker: Dr. Robert A. Kilduffe

Subject: Novel with Medical Interest

Bergen County

January 14, 1941, 9:00 p. m.

Holy Name Hospital, Teaneck, N. J.

Speaker: Mrs. Arthur F. Coca

Subject: Blood Group Studies of Primitive Peoples of the Far East

Burlington County

January 6, 1941, 2:00 p. m.

Zurbrugg Hospital, Riverside, N. J.

Tour of Zurbrugg Hospital

Tea

Camden County

January 7, 1941, 2:00 p. m.

Residence Mrs. A. H. Lippincott, 406 Cooper Street, Camden, N. J.

Speakers: An English refugee and a Chinese girl

Subjects: England and China

Tea

Essex County

January 27, 1941, 2:30 p. m.

Academy of Medicine, Newark, N. J.

Speaker: Mrs. Howard Hymer

Subject: International Relations

Gloucester County

January 9, 1941, 9:00 p. m.

Residence Mrs. C. A. Bowersox, 106 South Columbia Street, Woodbury, N. J.

Guests: Gloucester County physicians and wives

Speaker: Dr. William Pedrick

Subject: Travel Pictures

Hudson County

January 6, 1941, 2:00 p. m.

Young Woman's Christian Association, Jersey City, N. J.

Speaker: Miss S. Kennedy

Subject: Book Review

January 18, 1941

Midwinter party, fashion show, bridge and tea
Hotel Pierre, Fifth Avenue at 61st Street, New York City

Middlesex County

January 15, 1941, 8:30 p. m.

Residence Mrs. S. G. Berkow, 158 Kearny Avenue, Perth Amboy, N. J.

Business and social meeting

Passaic County

January 20, 1941, 1:00 p. m.

Alexander Hamilton Hotel, Paterson, N. J.

Speakers:

Mrs. Don A. Epler—Public Relations

Mrs. A. W. Bickner, Legislation

Luncheon

We wish to call the attention of the members to the listing of the business and social meetings of the County Auxiliaries, as above. Not all of the County Auxiliaries meet every month. However, it

is our intention to list the meetings for the convenience of the Auxiliary members. We hope, also, to promote inter-county visiting for the mutual benefit derived from knowing your neighbor.

COUNTY AUXILIARIES

Atlantic County

Mrs. Matthew Molitch, Publicity Chairman

The regular meeting of the *Woman's Auxiliary to the Atlantic County Medical Society* was held on Friday evening, December 13, 1940, and was in the form of a Christmas party. There were twenty-six members present.

A musical trio played several selections, and accompanied communal singing of Christmas carols by the ladies. Progressive games were played, and prizes were awarded the winners. A delicious repast was served.

Camden County

Reported by Mrs. E. R. Hirst, Chairman of Publicity

The Executive Board of the *Woman's Auxiliary to the Camden County Medical Society* met on Tuesday, December 3, at 10 a. m., at the home of the President, Mrs. L. L. Glover, who presided at the meeting. There were twenty-two members present.

Routine reports given by chairmen of committees were accepted.

The Program Chairman, Mrs. Robert S. Gamon, announced that the next regular meeting of the

Auxiliary will be held at the home of Mrs. A. H. Lippincott, 406 Cooper Street, Camden, N. J., on January 7, 1941. The program will consist of two guest speakers,—an English refugee, and a Chinese student. Tea will be served during the social period following.

The March meeting will be held in Woodbury, with the President-Elect, Mrs. O. R. Kline, as our hostess. Two members of the Auxiliary will give book reports.

The Public Relations Chairman, Mrs. Oswald R. Carlander, reported that the Public Relations meeting scheduled for March 25, 1941, will be an all-day session on the theme "Health Examinations". The social hour and lunch at noon will be in charge of the Hospitality Chairman.

One member of the Auxiliary to represent the Parent-Teacher Association, and one to represent the Woman's Club, were named to serve on Mrs. Carlander's Committee on Public Relations.

The Membership Chairman sent a report of one new member; and that there are several eligible to join.

The Finance Chairman, Mrs. Gordon F. West, presented the proposed budget for 1940-1941, and

also reported that Oppenheim and Collins, Philadelphia, Pa., will give a Fashion Show at the Card Party March 3, 1941.

The Widows and Orphans Chairman, Mrs. Thomas P. McConaghy, again stressed the importance of our husbands becoming members of this society, and stated cases where the families had been greatly benefited during a very difficult financial period.

The Courtesy Chairman, Mrs. E. G. Hummell, reported flowers sent at Thanksgiving to Mrs. Joel Fithian, Historian, who is ill. A card shower will be given her at Christmas. Mrs. M. L. Weimann was appointed Co-chairman with Historian.

The Chairman of The Bulletin, Mrs. Edward C. Hessart, urged all Auxiliary members to subscribe and coöperate 100 per cent in its distribution.

It was moved, seconded and carried that the Auxiliary recommend Dr. Mabel G. Leshner, of Camden, N. J., as an applicant for the Gimbel Reward, given annually in recognition of outstanding welfare work and willing contribution to the Youth of America.

Coffee was served by our hostess preceding the meeting, and was thoroughly enjoyed by all.

Gloucester County

Reported by Mrs. C. A. Bowersox, Chairman of Public Relations

The *Woman's Auxiliary to the Gloucester County Medical Society* held its Christmas party on Friday, December 13th, at the home of Mrs. Thomas M. Gairdner, Gibbstown. There were twenty-two members and guests present.

Mrs. Russel de Hart, of Woodbury, gave a talk on antique glass.

Tea was served after the program.

Hudson County

Reported by Mrs. Sydney Chayes, Chairman of Publicity

The annual Christmas party of the *Woman's Auxiliary to the Hudson County Medical Society* was held on Monday, December 2, at the Young Woman's Christian Association, 270 Fairmont Avenue, Jersey City, N. J. Mrs. Arthur Largay, President, welcomed the guests.

The clubroom of the "Y" was decorated with Christmas greens, and the Yule log burned brightly in the fireplace. All during the afternoon, the Flint Trio of East Orange, which is composed of mother, daughter and son, played traditional Christmas airs. Mrs. John Nevin, former President, gave a dramatic reading on the "Doctor of the Old School"; and Jimmie Dick Cogan, a well-known boy soprano from

Bayonne, sang a group of Christmas carols with Mrs. Gertrude Walsh as accompanist.

"Santa Claus" in the person of Mrs. Henry Klaus, of Union City, was present and distributed gifts among the members. Later tea was served.

Mercer County

Reported by Mrs. A. F. Moriconi, Chairman of Publicity Committee

The regular meeting of the *Woman's Auxiliary to the Mercer County Medical Society* was held on Monday, November 25, at Mercer Hospital. Mrs. G. N. J. Sommer presided.

Arrangements were made for Christmas cheer gifts to be given to all hospitals in Mercer County.

Mrs. Richard J. McDonald, the President of the State Auxiliary, addressed the group on the increasing importance of furthering public relations. She also spoke praisingly of the Bulletin of the Woman's Auxiliary to the American Medical Association, and expressed the desire that all local members subscribe.

Mrs. McDonald explained the benefits to be derived from joining in with the Widows' and Orphans' Insurance sponsored by The Medical Society of New Jersey.

The meeting was preceded by a luncheon, and earlier in the day dressings were made.

Union County

Reported by Mrs. Rowland P. Blythe, Publicity Chairman

The first Fall meeting of the *Woman's Auxiliary to the Union County Medical Society* was held on the afternoon of Wednesday, September 25, at the William Pitt Tavern in Chatham, with the President, Mrs. H. S. Murphy, presiding at a luncheon.

Mrs. Roy A. Albright, of Roselle, gave an illustrated talk on handcraft.

Mrs. Murphy reported on a meeting of the Executive Board in her home on September 18, with twelve members present. Plans for the coming year were discussed.

The November meeting was held in the home of Mrs. H. V. Hubbard, Plainfield, with thirty members and guests present.

Mrs. A. H. Lippincott, of Camden, Commander of the New Jersey Branch of the American Field Army for the Control of Cancer, described the educational work that is done by the State branch.

Tea was served by the hostess at the close of the meeting.

BOOKS RECEIVED FOR REVIEW

The books listed in these columns may be seen at the Library of the Academy of Medicine of Northern New Jersey.

Fractures and Dislocations. By Edwin O. Geckeler, M.D. 2d ed. Pp. 314. Baltimore, Williams & Wilkins Company. 1940. \$4.00.

Public Health Administration in the United States. By Wilson G. Smillie, M.D. 3d ed. Pp. 553. New York, The Macmillan Co. 1941. \$3.75.

Foreign Bodies Left in the Abdomen. By Harry Sturgeon Crossen, M.D., and David Frederic Cross-

sen, M.D. Pp. 762. St. Louis, C. V. Mosby Co. 1941. \$10.00.

Methods of Treatment. By Logan Clendening, M.D., and Edward H. Hashinger, A.B., M.D. 7th ed. Pp. 997. St. Louis, C. V. Mosby Co. 1941. \$10.00.

More Years for the Asking. By Peter J. Steincrohn, M.D. Pp. 218. New York, D. Appleton-Century Co. 1940. \$2.00.

Treatment of Diabetes Mellitus. By Elliott P. Joslin, M.D., Sc.D. 7th ed. Pp. 783 with 117 tables. Philadelphia, Lea & Febiger. 1940. \$7.50.

BOOK REVIEWS

DIAGNOSIS AND TREATMENT OF DISEASES OF THE HAIR. By Lee McCarthy. Pp. 871. Price \$9.50. St. Louis, C. V. Mosby Company. 1940.

This is a well written and easily read book. The subject matter is thoroughly covered, including anatomy, physiology, pigmentation, trophic disturbances, and inflammatory diseases of hair follicles.

There are 291 illustrations, including fine photographs of various cultures.

Growths on the scalp having an influence on the development and structure of the hair are included.

The book will be a valuable edition to a dermatologist's library.

FRANCIS J. MCCAULEY.

PNEUMONOCOONIOSIS (SILICOSIS), THE STORY OF DUSTY LUNGS; a preliminary report by Lewis Gregory Cole and William Cole. Pp. 290. Price \$1.00. New York, John B. Pierce Foundation. 1940.

Although the evidence on which the authors' findings and conclusions are based is available at the John B. Pierce Foundation in New York City, it will be inconvenient, if not impossible, for many to visit the foundation. It would seem, therefore, that the book would have been of considerably greater value if some of the many photomicrographs had been included as illustrations.

The authors began their study of pneumoconiosis as a hobby about four years ago; and in May, 1938, they received the support of the John B. Pierce Foundation.

Ideas somewhat in variance with the accepted views are presented, and the definition of silicosis adopted by the Industrial Hygiene Committee of America in 1932 is criticized.

The authors classify and discuss the four types according to pathological and roentgenological findings: 1, The perivascular-peribronchial-lymph-node manifestation; 2, the nodular type; 3, the pock-marking type; and 4, acute silicosis. Each type is discussed in detail.

In Chapter Four on roentgenology, the authors suggested that the clinician make his examination and base his opinion on clinical evidence without knowledge of the roentgen findings, while the roentgenologist should base his opinion solely on his observations and an interpretation of the roentgen

findings with total disregard for clinical history or even exposure to a dust hazard. A consultation can then reconcile any difference of opinion. Carman arrived at the same conclusion regarding diagnosis of diseases of the stomach and intestines.

This book certainly deserves to be read carefully by all those interested in the subject and should stimulate others to further study of the disease.

JAMES B. MARQUIS.

CHEMOTHERAPY AND SERUM THERAPY OF PNEUMONIA. By Frederick T. Lord, E. S. Robinson and R. Heffron. Pp. 174. \$1.00. N. Y., Commonwealth Fund. 1940.

A previous edition of this book published two years ago under the title *Pneumonia and Serum Therapy* was reviewed in this Journal in March, 1938. The present edition is supplemented by the chapter on chemotherapy.

The practicing physician has been so thoroughly informed during the past years by clinical reports and reports of experimental work in vitro and vivo with the sulfanilamide group of chemicals that this handbook can hardly bring anything new on the subject. However, it gives a nice summary of the results obtained with these drugs and can, therefore, be recommended to the busy doctor. The technic of administration, dosage, rapidity of absorption, blood concentration, drug fever, granulocytopenia, hemolytic anemia, jaundice, hematuria and the formation of kidney stones are sufficiently discussed. Attention is called to sulfathiazole, which is as effective as sulfapyridine. The quinine derivatives are briefly mentioned. The current technic of serum therapy is described, and the indications for and technic of the combined use of serum and chemotherapy are adequately covered.

FELIX BAUM.

CLINICAL HEART DISEASE. By Samuel A. Levine, M.D. 2d ed. Pp. 495. Philadelphia, W. B. Saunders & Co. 1940. \$6.00.

The first edition of this excellent book was justifiably very popular. The author, whose experiences have been wide and varied, wrote well and lucidly on heart disease in a fashion that helped rather than confused the reader. However, as excellent as

the first edition was, the present volume is a distinct step forward in the teaching of cardiology. Not only has the author included the newer concepts on the mechanism of heart failure and the use of digitalis, and some of the more recent changes in electrocardiography, but also a chapter on the medico-legal aspects of cardiography. This chapter points out the pitfalls which beset the physician in attempting to decide whether or not a given injury is capable of causing cardiac damage, as well as a short discussion of the so-called "Total and Permanent Disability" clauses found in many insurance policies.

This book, therefore, can be recommended not only to the cardiologist, but to the general practitioner.

A. E. P.

PRACTICAL BEDSIDE DIAGNOSIS AND TREATMENT. By Henry Joachim, M.D. Pp. 334. Springfield, Illinois, Charles C. Thomas. 1940. \$7.50.

This work differs from others on the same subject in that it expresses the observations and opinions of one clinician, and makes little attempt to present the work of others, even to the extent of a single bibliographic reference. Here lies its strength, and its weakness. The physician with a knowledge of the principles of physical and laboratory diagnosis will find the book valuable. The medical student attempting to get the most out of the book should keep a medical dictionary and a good fundamental work on physical diagnosis at his side for interpretation of the many signs mentioned.

No doubt the author would welcome, with us, the invention of some entirely new sounding words to replace "may be", "often occurs", etc. This does not minimize, however, the fact that the author has amply given the benefit of his wide experience, and that the publishers have lived up to their usual high standard of excellence.

TEXTBOOK OF MEDICINE BY AMERICAN AUTHORS. Edited by Russell L. Cecil, M.D. 5th ed. Pp. 1744. Philadelphia, W. B. Saunders Company. 1940. \$9.50.

This volume has a freshness and readability lacking in most of the older textbooks of medicine. The book is now appearing in its fifth edition, evidence both of its popularity among students and practicing physicians, and of the desire of its author and publishers to keep it up to date. It is a collection of monographs, each dealing with one disease or group of related diseases, and each written by a recognized authority on that subject. There are 144 monographs in the volume carefully edited and arranged by the author and his associate editor for diseases of the nervous system, Foster Kennedy, M.D.

Each monograph covers the essential facts, and there is little verbosity or padding. The contributors are not only well known, but are actively engaged in their various fields at the present time, and are presenting their own first-hand knowledge.

The bibliographies are adequate for this type of text-book. The printing is good, and the type is

clear and easy to read. A large index is well planned and comprehensive. The illustrations add very little to the value of the book and all but charts and graphs could just as well be omitted.

HARVEY W. EWING.

PRINCIPLES OF HEMATOLOGY. By Russell L. Haden, M.D. 2d ed. Pp. 362. Philadelphia, Lea & Febiger. 1940. \$4.50.

Dr. Haden, in his second edition of "Principles of Hematology", has avoided an excessive amount of technology, and yet has retained all the essentials that make the book practical for teaching and for reference. Its illustrations will make the book valuable to the technical hematologist.

It is gratifying to see that the stomach and liver have been placed in the hematopoietic system. The methods are given completely and freely,—which is of great value. The case illustrations are interesting, but have the appearance of having been used to fill out the book. There are some mathematical errors in the congo red determinations, and in the indexing of cases, which makes them somewhat confusing. These, however, are not very serious, and do not detract from the obvious merits of a very fine book.

MURRAY W. SHULMAN.

PHYSICAL THERAPY FOR NURSES. By Richard Kovács. 2d ed. Pp. 335. Philadelphia, Lea & Febiger. 1940. \$3.25.

This second edition is more extensive than the first, and contains additional chapters on fever therapy, short wave diathermy, and colonic irrigation which are of considerable value. The book is most suited for post-graduate teaching of nurses, although it may also serve as a reference book for undergraduates. The latter, however, may find the wealth of information a bit bewildering. The importance of physical therapy is such that this volume should be in the library of every training school, and in the hands of every worker in the field.

DIAGNOSIS AND TREATMENT OF PULMONARY TUBERCULOSIS. By John B. Hawes, 2d, M.D., and Moses J. Stone, M.D. 2d ed. Pp. 260. Philadelphia, Lea & Febiger. 1940. \$2.75.

This is an excellent book on pulmonary tuberculosis for the general practitioner. The contents of each chapter is summarized at its end. The importance of x-ray examination of the chest in cases of chronic cough, and the diagnosis of possible tubercular lesions of lung by examination of gastric lavage specimens, are stressed. There is a sound discussion about dietary regime and climatic conditions in the treatment of the tuberculous patient, and the use of extrapleural pneumothorax in the aged is emphasized.

On the whole, this small volume can be well recommended to the general practitioner as a summary of the methods used at the present time in the diagnosis and treatment of pulmonary tuberculosis.

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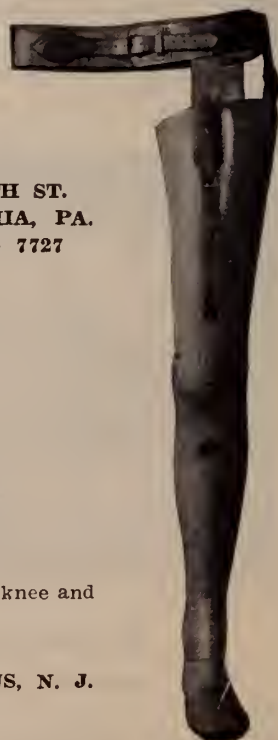
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Roster of Officers on Advertising Page III

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(DUE TO NEISSERIA GONORRHEAE)

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JOHN WYETH & BROTHER, INCORPORATED, PHILA.

Silver Picrate, Wyeth, has a convincing record of effectiveness as a local treatment for acute anterior urethritis caused by Neisseria gonorrhoeae. (1) An aqueous solution (0.5 per cent) of silver picrate or water-soluble jelly (0.5 per cent) are employed in the treatment.

1. Knight, F., and Shelanski, H. A., "Treatment of Acute Anterior Urethritis with Silver Picrate," Am. J. Syph. Gon. & Ven. Dis., 23, 201 (March) 1939.

*Silver Picrate, is a definite crystalline compound of silver and picric acid. It is available in the form of crystals and soluble trituration for the preparation of solutions, suppositories, water-soluble jelly, and powder for vaginal insufflation.

THE MEDICAL SOCIETY OF NEW JERSEY

Announces

MEDICAL SERVICE ADMINISTRATION OF NEW JERSEY

NON PROFIT

Devoted to the Distribution of Adequate Medical Care

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(Supplement to The Journal of The Medical Society of New Jersey, February, 1911)

SEQUENCE OF EVENTS IN THE DEVELOPMENT OF THE MEDICAL SERVICE ADMINISTRATION

1. September, 1938 — "Fact-Finding Committee" appointed by President Carrington,—Dr. Hilton Read, Chairman.
2. December, 1938 — Above Committee reported, stating, "We believe some form of voluntary indemnity insurance can be evolved."
3. January, 1939 — Voluntary Health Insurance Committee appointed,—Dr. E. W. Sprague, Chairman.
4. February, 1939—Committee reported to the Welfare Committee on "Fundamental Principles of a Plan."
5. February, 1939—Founding Committee appointed, retaining the membership of the previous Committee,—Dr. E. W. Lance, Chairman.
6. June, 1939—Committee reported to House of Delegates, presenting The Medical Service Plan of New Jersey. Plan approved and instructions given to inaugurate the Plan.
7. June, 1939—President Hawkes, in the name of the Board of Trustees, appointed the Board of Governors of The Medical Service Plan of New Jersey.
8. July, 1939—Medical Service Plan incorporated under the laws of New Jersey, as a non-profit corporation.
9. August, 1939—The Commissioner of Banking and Insurance ruled the Plan constituted "insurance", and would require an enabling act and licensing by the Commissioner.
10. November, 1939—The Board of Trustees of The Medical Society of New Jersey instructed the Board of Governors to prepare an enabling act.
11. January, 1940—The Board of Trustees approved (1) the enabling bill, allowing the incorporation of medical service corporations, and (2) reincorporation and the organization of Medical Service Administration.
12. March, 1940—Senate Bill 108 introduced into Legislature by Senator I. Grant Scott of Cape May County.
13. April, 1940—Senate Bill 108 passed the Senate, 16-1.
14. May 6, 1940—Senate Bill 108 passed Assembly without a dissenting vote.
15. May 29, 1940—Enabling Bill signed by Governor Moore.
16. June 3, 1940—Board of Trustees approved Farm Security Medical Plan.
17. June 5, 1940—Medical Service Administration approved by House of Delegates.
18. June 6, 1940—Medical Service Administration incorporated by amendment of incorporation papers of The Medical Service Plan.
19. July 7, 1940—Medical and Surgical Plan for Hospitalized Patients approved by Board of Trustees.
20. November 27, 1940—House of Delegates in special meeting approved Medical Service Administration and all proposed plans, and advanced a total of \$11,000 for operation of the Administration for a period of one year.
21. February 1, 1941—Medical Service Administration announced by The Medical Society of New Jersey. The Administration opened offices at 143 East State Street, Trenton, New Jersey.

MEDICAL SERVICE ADMINISTRATION OF NEW JERSEY

TRENTON, NEW JERSEY

Agreement of Participating Physician

I, THE UNDERSIGNED, do hereby agree to become a Participating Physician of Medical Service Administration of New Jersey, pursuant to Chapter 74, Laws of 1940 of New Jersey, and acts supplementary thereto and amendatory thereof.

I agree with Medical Service Administration of New Jersey to perform medical services specified in the subscription certificates issued by the Administration, which specified medical services shall be in accordance with accepted practices in the community at the time the service is rendered and at such rates of compensation as shall be determined by the Board of Governors of the Administration. I further agree to abide by the By-Laws, Rules and Regulations of the Administration applicable to Participating Physicians, and acknowledge the receipt of a copy of such By-Laws, Rules and Regulations.

This Agreement may be terminated by me by written notice to the Board of Governors. Such termination shall not be effective as to any certificate in force at the time of such notice until the first date thereafter when such certificate may be canceled by the Administration. This Agreement for the rendering of service to the end of the current certificate year of each certificate in force at the date of notice of termination of this Agreement shall not be affected by cessation of the transaction of business by the Administration as a result of action of the Board of Governors, injunction issued by a court of competent authority, legislative act, or by any other exercise of judicial, administrative or legislative authority.

Approved for Acceptance

Signed

..... M.D.
Medical Director, Medical Service
Administration of New Jersey.

..... M.D.

Date

..... County

Please sign and return this agreement to Medical Service Administration,
143 East State Street, Trenton, N. J.

MEDICAL SERVICE ADMINISTRATION OF NEW JERSEY

BOARD OF GOVERNORS



ELTON W. LANCE, M.D.
President
General Practitioner
Rahway



JOHN S. THOMPSON
Secretary
Vice-President, Mutual Benefit
Life Insurance Co., Newark



AUGUSTUS S. KNIGHT, M.D.
Treasurer
Medical Director, Metropolitan
Life Insurance Co., Retired
Far Hills



JOSEPH BIGLEY
Executive Director, Brooklyn
Chapter, American Red Cross
Elizabeth



EDWARD W. SPRAGUE, M.D.
General Surgeon
Newark



GEORGE W. MERCK
President, Merck and Co., Inc.
Rahway



WM. G. HERRMAN, M.D.
Radiologist, Asbury Park
Past President of Society



WM. J. CARRINGTON, M.D.
Gynecologist, Atlantic City
Past President of Society

EXECUTIVE STAFF



NORMAN M. SCOTT, M.D.
Medical Director
Trenton



JOSEPH J. HART
Executive Secretary
Trenton

An Obligation and Responsibility

The One Hundred and Sixty-fourth Session of the Legislature of New Jersey, in April, 1940, conferred upon The Medical Society of New Jersey the authority which will assist the profession in guiding and controlling certain proposed changes in the methods of distributing medical care.

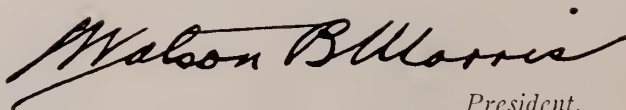
This legislative authority will permit the continued control of the private practice of medicine by the medical profession, the alternative of which might be the control of many phases of practice by a Federal, or State, or lay agency.

In granting this privilege to the medical profession, the Legislators have implied their confidence in the sincerity of the practicing physicians of New Jersey. They granted us official support presumably because of their respect for our profession, and because of their belief that the members of the profession, both as an organized body and as individual physicians, are best qualified by training and experience to investigate and propose a solution for important medico-economic problems.

We, the medical profession of New Jersey, must be sincere and active in our efforts to carry out the provisions that have been authorized by the State Legislature. If we are not, we will have no logical argument or redress if a political or lay agency outside of the medical profession is given legislative authority to direct the distribution of medical care. We must justify the faith of the Legislators in our assertion that we have both the *ability* and the *will* to direct the distribution of medical services.

To carry out the authority vested in us, The Medical Society of New Jersey is sponsoring Medical Service Administration. It is your organization, administered under the supervision and control of a group of your members. All future activities will require the approval of the Board of Trustees and the House of Delegates of The Medical Society of New Jersey. Your support as a participating physician will assist in making this agency a success.

I therefore commend Medical Service Administration to you in the name of The Medical Society of New Jersey; and urgently request that you express your support of the efforts of this Society in your behalf, by becoming a participating physician.



President,
The Medical Society of New Jersey.

Evolution of Medical Service Administration

In 1938 the private practice of medicine was jeopardized by activities which culminated in an abortive attempt to establish a national health plan. This action was predicated on the assertion by Federal agencies that a large group of our population was not receiving adequate medical care.

A thorough survey, made in 1938-39, determined beyond doubt that adequate facilities and opportunities for obtaining medical care were available to all citizens of New Jersey. This survey also demonstrated that private practitioners were carrying a tremendous economic load in the form of medical care rendered without charge to the indigent, and to private patients of the low-income group who were not able to pay for the services rendered. There was no evidence to indicate that the *indigent* could not obtain adequate medical care.

It was quite apparent that, if a defect did exist in our methods of distributing medical care, it was among the low-wage group. The members of this group are above the level of true indigency. They are self-respecting, responsible citizens, able to fulfill their ordinary obligations of self-support; but when seriously ill, are unable to pay for adequate medical care, and are thus forced into a state of *medical* indigency.

In answer to the above problem, your Committees have advised the organization of voluntary medical service plans to be operated by a medical service corporation authorized under Chapter 74 of the Laws of 1940 of New Jersey, and sponsored by The Medical Society of New Jersey. Each step in the evolution of this solution has been reported to and approved by the Board of Trustees, the Welfare Committee, and the House of Delegates of The Medical Society of New Jersey.

During its evolution we have been acutely conscious of our obligations and responsibilities to the profession. We have done our best to protect the personal interests of all physicians and maintain the high standards of the practice of medicine.

Medical Service Administration may operate any type of plan to promote the distribution of medical care, to be paid for by Federal, State, or private grants, or by voluntary insurance subscriptions. It will be administered and controlled by physicians, must provide for free choice of physician and patient, and must not interfere with physician-patient relationship. It must limit its activities to providing payment for adequate medical care "in accordance with accepted practices in local communities", rendered by physicians holding a full license to practice medicine.

The Administration will not be registered in any county without the approval of that County Medical Society. It will not operate any plan in any county without that County Society's approval of the specific plan.

The Medical Society of New Jersey has authorized the operation of Medical Service Administration for one year as an experiment, with the provision that its continuation will depend upon the decision of the physicians of New Jersey as expressed through the House of Delegates.

Ell Lance

President,

Medical Service Administration.

Among the first thousand physicians signing "Agreement of Participating Physicians" are

- Alexander, Samuel, Member of the Board of Trustees
 Ash, Frank W., President of Passaic County Medical Society
 Barkhorn, Henry C., Chairman of the Publication Committee
 Beling, Christopher C., Chairman of Medical Defense and Insurance Committee
 Bingham, Arthur W., Chairman of Advisory Committee on Maternal Welfare
 Brown, Chester R., Chairman of Advisory Committee on Child Health
 Buchanan, Ralph M., President of Warren County Medical Society
 Butcher, Charles, President of Cumberland County Medical Society
 Carrington, William J., Fellow of The Medical Society of New Jersey
 Comando, Harry N., President of Essex County Medical Society
 Conway, Walt P., Fellow of The Medical Society of New Jersey
 Cooper, J. Howard, President of Somerset County Medical Society
 Costello, William F., Chairman of the Board of Trustees of The Medical Society of New Jersey
 Cox, Harold C., President of Mercer County Medical Society
 Crowe, Aldrich C., President of Cape May County Medical Society and member of the Board of Trustees of The Medical Society of New Jersey
 Davison, Wilbur S., President of Salem County Medical Society
 Decker, Henry B., Chairman of Advisory Committee on Hospital Relationships
 Diverty, Henry B., President of Gloucester County Medical Society
 Dodd, William E., President of Ocean County Medical Society
 Eagleton, Wells P., Fellow of The Medical Society of New Jersey
 Ely, Lancelot, Fellow of The Medical Society of New Jersey
 Faulkingham, R. J., President of Middlesex County Medical Society
 Featherston, Daniel F., President of Monmouth County Medical Society
 Fithian, George W., Member of the Board of Trustees of The Medical Society of New Jersey
 Gamon, R. S., President of Camden County Medical Society
 Gibb, W. Blake, President of Morris County Medical Society
 Ginsberg, George, President of Hudson County Medical Society
 Green, David W., Member of the Board of Trustees of The Medical Society of New Jersey
 Harryman, William K., Chairman of Advisory Committee on Workmen's Compensation
 Hawkes, E. Zeh, Fellow of The Medical Society of New Jersey
 Hawkes, Stuart Z., Chairman of Committee on Post-Graduate Education
 Herrman, William G., Fellow of The Medical Society of New Jersey
 Hollinshead, R. K., Member of the Board of Trustees of The Medical Society of New Jersey, and Second Vice-President of the Medical Society
 Hornberger, J. Howard, Member of the Board of Trustees of The Medical Society of New Jersey
 Ill, Edgar A., Chairman of the Advisory Committee on Cancer Control
 Johnson, V. Earl, President of Atlantic County Medical Society
 Knauer, George, President of Union County Medical Society
 Lee, Thomas B., Member of the Board of Trustees of The Medical Society of New Jersey
 Lewis, Thomas K., President-Elect of The Medical Society of New Jersey
 Marsh, E. J., First Vice-President of The Medical Society of New Jersey
 McBride, Andrew F., Fellow of The Medical Society of New Jersey
 McCall, Jesse, President of Sussex County Medical Society
 Morris, Watson B., President of The Medical Society of New Jersey
 Murphy, Herschel S., Chairman of the Advisory Committee on Medical Care of the Indigent and Low-Wage Groups
 Newcomb, M. W., Fellow of The Medical Society of New Jersey
 North, Harry R., Chairman of the Finance and Budget Committee and Member of the Board of Trustees of The Medical Society of New Jersey
 Norton, James F., Member of the Board of Trustees of The Medical Society of New Jersey
 Pollak, B. S., Chairman of the Sub-Committee on Legislation
 Quigley, Frederic J., Fellow of The Medical Society of New Jersey
 Raycroft, J. E., Chairman of the Advisory Committee on Mental Hygiene
 Read, Hilton S., Chairman of the Welfare Committee
 Robbins, Charles M., Chairman of the Sub-Committee on Public Relations
 Sewall, Millard F., Chairman of Advisory Committee on Traffic Accidents
 Sherman, Elbert S., Chairman of Advisory Committee on Conservation of Vision
 Smith, Ivan B., President of Hunterdon County Medical Society
 Snedecor, Spencer T., Fellow of The Medical Society of New Jersey
 Sommer, George N. J., Fellow of The Medical Society of New Jersey
 Stahl, Alfred, Secretary of The Medical Society of New Jersey
 Tether, Russell K., President of Bergen County Medical Society
 Tracy, George T., President of Burlington County Medical Society
 Ulmer, Chester I., Chairman of the Advisory Committee on Pharmaceutical Problems
 Varney, William H., Chairman of the Advisory Committee on Adult Health Supervision.
 Weigel, Elmer P., Chairman of the Advisory Committee on Crippled Children
 Young, George J., Treasurer of The Medical Society of New Jersey
 Zehnder, A. Charles, Chairman of the Advisory Committee on Nursing and Nursing Education

A LETTER FROM THE HONORABLE A. HARRY MOORE

A. HARRY MOORE

THE GOVERNOR OF NEW JERSEY

January 21, 1941.

Dear Doctor:

One of the splendid memories of my administration will be the fine coöperation of The Medical Society of New Jersey. You may believe me when I say that my regard for your Society is very great and I rejoice in the fact that you have always been ready to help the people of New Jersey who needed it, and you were willing to do so without any hope of reward.

You have always sought out ways and means of being helpful to the people and your new plans will be of incalculable value.

With every sentiment of regard, I am

Sincerely yours,

(Signed) A. HARRY MOORE.

EXTRACTS FROM PRESS AND CURRENT PUBLICATIONS

THE EASTERN UNDERWRITER:—from an article by C. A. Togut, a recognized medical economist.

"No voluntary medical expense plan can operate successfully and beneficially without the unanimous and energetic endorsement of the medical profession. The law presupposes this support; the public will demand it. A house divided is a house perished in the consumer's eyes. The tremendous strides recorded by the Associated Hospital Service of New York have been due almost entirely to the solidarity of purpose and endorsement of its member hospitals. There can be no competitive plan because the 'three cents a day plan' enjoys a virtual monopoly by the grace of its member hospitals and their unfaltering determination to fight for the endeavor."

DAILY NEWS, Brooklyn:—from address by Justice R. Foster Piper, who, as a member of the State Legislature, introduced the New York Medical Corporation Insurance Law, authorizing voluntary insurance medical plans.

"If after a few years it is found these corporations are not set up and functioning effectively, there appears to be nothing left to do except to establish state health insurance."

RESUME OF PLANS

PLAN No. I

The Medical Service Plan of New Jersey is a full coverage plan to reach persons with a maximum annual family income of \$1600, with an additional \$400 annually for the wife and \$200 additional for each dependent child.

PLAN No. II

The Medical-Surgical Service Plan for Hospitalized Patients is designed to benefit employed persons only. The upper income limit of subscribers will be \$2,000. It will pay for

medical, surgical and auxilliary services rendered while the subscriber is a bed patient in an approved hospital, under the care of a private physician.

PLAN No. III

The Farm Security Plan is sponsored by the Federal Farm Security Administration for the benefit of the semi-indigent farmer who has borrowed money from the Farm Security Administration and who has no other source of credit. It is similar to the E. R. A. medical plan, and must be on a state-wide basis.

The By-Laws of the Administration and the Rules and Regulations of each Plan will be found on succeeding pages.

BY-LAWS OF MEDICAL SERVICE ADMINISTRATION OF NEW JERSEY

(A Non-Profit Corporation)

Sponsored by The Medical Society of New Jersey

CHAPTER I

NAME

The name of this corporation is Medical Service Administration of New Jersey.

CHAPTER II

PURPOSES

The purposes of Medical Service Administration are:

(a) To assist selected groups of persons to secure Medical and Surgical Services. Such services shall be provided by physicians holding full licenses to practice medicine and surgery according to the laws of the State of New Jersey.

(b) To accomplish the above purpose by the establishment of medical service plans or arrangements. These plans or arrangements shall operate on a non-profit, voluntary basis which preserves the patient-physician relationship and allows the free choice of physician and patient.

CHAPTER III

ORGANIZATION

Section 1—*Members of the Administration.*

(a) Membership in the Administration shall be limited to the Board of Governors. The Board of Governors shall consist of eight (8) members.

(b) They shall be appointed by the Board of Trustees of The Medical Society of New Jersey.

(c) At least five of the Board of Governors shall be members in good standing of The Medical Society of New Jersey.

Section 2—*Terms of Appointment.*—The terms of appointment shall be as follows:

Three (3) appointments for three (3) years.

Three (3) appointments for two (2) years.

Two (2) appointments for one (1) year.

CHAPTER IV

MEETINGS

Section 1—*Organization Meeting.*—An organization meeting of the Administration shall be held within one month after the receipt of the certified copy of the certificate of incorporation.

Section 2—*Regular Meetings.*—Regular

meetings shall be held each month. Special meetings shall be held at the call of the President. Meetings shall be held at such time and place as is determined by the President.

Section 3—*Annual Meeting.*—An annual meeting of the Administration shall be held on a date coinciding with the date of the annual meeting of The Medical Society of New Jersey.

Section 4—*Quorum.*—A quorum of the Board of Governors shall consist of a majority of the members of the Board. The majority of such quorum shall be medical members.

A decision of the Board of Governors shall require a majority vote of the members present.

Section 5—*Voting Privileges.*—Voting privileges in the Administration shall be limited to the members of the Board of Governors.

Section 6—*Notice of Meetings.*—Notice of any regular meeting of the Board of Governors shall be mailed to all members at least five days prior to the date of meetings. This notice shall contain the agenda for the meeting.

Section 7—*Meetings on Demand.*—The President shall, upon due notice of demand by any five (5) members of the Board, call a special meeting, to be convened within twenty-one (21) days of the receipt of such notice.

CHAPTER V

OFFICERS

The officers of the Administration shall be a President, Vice-President, Secretary, and Treasurer. At the first meeting of the Board of Governors, the Board shall elect from among its members a President, Vice-President, Secretary, and Treasurer of the Administration, to act in such capacities until the following annual meeting of the Board.

At each annual meeting a President, Vice-President, Secretary, and Treasurer of the Administration shall be elected from among the members of the Board, to serve for a period of one year.

CHAPTER VI

MANAGEMENT

The Administration shall be operated and managed by the Board of Governors.

Section 1—*Duties of the Board of Governors.*

(a) The Board of Governors shall determine all policies, rules and regulations governing the management of the Administration and plans or arrangements operated by the Administration.

(b) The Board shall appoint all administrative officers of the Administration.

(c) The Board shall appoint a Medical Director and such Assistant Medical Directors as are considered necessary for the operation of plans or arrangements.

(d) The Board shall control the disbursement of the funds of the Administration.

(e) The Board shall approve the acceptance of all new participants under the plans or arrangements operated by the Administration.

(f) The Board shall make a decision pertaining to any questions involving the Administration, plans or arrangements operated by the Administration, or participants under the plans or arrangements, which are brought before it for consideration.

(g) The Board shall hear the appeal of any participant under a plan or arrangement operated by the Administration on matters involving the relationship of a participant with any other participant, or his relationship to the Administration or plans or arrangements operated by the Administration.

(h) Executive Committee.—There shall be an Executive Committee of the Administration. It shall be composed of the President, the Secretary and one member of the Board elected by the members of the Board. The Committee shall be vested with all powers of the Board of Governors between meetings of the Board, and shall report in writing at the next meeting of the Board all actions taken.

(i) The Board representing the Administration shall not disburse during any one calendar year more than ten per centum (10%) of the aggregate amount of payments received from subscribers during that year as expenditures for the solicitation of subscribers except that during the first year after the issuance of the certificate of authority, the Administration may so disburse not more than twenty per centum (20%) of such amount and during the second year not more than fifteen per centum (15%).

(j) The Board in the name of the Administration shall not disburse during any one year, a sum greater than twenty per centum (20%) of payments received from subscribers during that year as administra-

tive expenses. The term "administrative expense" shall include all expenditures for non-professional service and in general all expenses not directly connected with the payment for medical services, but shall not include expenses of soliciting subscriptions.

(k) The funds of the Administration may be invested only in accordance with the requirements now or hereafter provided by law for the investment of funds of life insurance companies. After the first calendar year of doing business, the Administration shall accumulate and maintain a special contingent surplus over and above its reserves and liabilities at the rate of two per centum (2%) annually of its net premium income until such surplus shall be not less than one hundred thousand dollars (\$100,000.00). This contingent surplus need not exceed, at any time, fifty-five per centum (55%) of the average annual premium income of the Administration for the previous five years.

(l) The Board shall furnish to each Subscriber on request, the names of the participating physicians residing in the county of the subscriber.

Section 2—*Duties of Officers.*

(a) The President shall preside at all meetings of the Board of Governors. He shall call all special meetings of the Board and shall designate the time and place of all meetings of the Board. He shall appoint all committees not otherwise provided for and shall be an ex-officio member of all such committees. He shall perform such other duties as custom and parliamentary usage may require.

(b) The Vice-President shall assume the duties and obligations designated to him by the President. He shall, in the absence of the President, assume all the responsibilities and obligations of the President.

(c) The Secretary shall issue or cause to be issued notices of all meetings of the Board of Governors. He shall keep a record of all meetings of the Board and shall keep or cause to be kept all records necessary to the proper functioning of the Administration.

(d) The Treasurer shall have the care and custody of all funds and securities of the Administration, shall establish or cause to be established a proper system of book-keeping and accounting of the funds of the Administration, depositing in a bank approved by the Board of Governors all monies received. He shall be responsible to the Administration for the custody and expenditure of the funds of the Administration as

set forth in the certificate of incorporation and the by-laws of the Administration. No funds will be distributed in the form of dividends.

(e) The Treasurer and such other officers and employees of the Administration as may be designated by the Board of Governors shall be bonded at the expense of the Administration and in amounts to be determined by the Board of Governors.

Section 3—*Executive Medical Director.*

(a) Shall be appointed by the Board of Governors.

(b) Shall represent the Board of Governors in the interval between meetings of the Board, and such action as he takes shall be passed upon by the Board of Governors at its next meeting.

(c) Shall examine the qualifications of all applicants for participation as professional or beneficiary participants in any plan or arrangement operated by the Administration, and accept applicants with satisfactory qualifications in the name of the Board of Governors.

(d) Shall be in charge of all administrative details relative to the operation of all plans or arrangements, including the employment and supervision of necessary administrative personnel and the distribution of the funds of the Administration, subject to the approval of the Board of Governors.

(e) Shall be responsible only to the Board of Governors, and his decisions will be made according to policies adopted by the Board.

(f) Shall be compensated as a part-time or full-time employee as determined by the Board of Governors.

Section 4—*Contracts.*

(a) All contracts with subscribers under the provisions of any plan or arrangement operated by the Administration shall be in the name of the Administration. All contracts with Subscribers will be made with each individual subscriber, except that contracts to provide payment for services rendered to subscriber and dependents shall be in the form of a family contract. The above shall not apply to the administration of plans and arrangements, financed by funds received from any governmental agencies, private agencies, corporations, associations, groups of individuals or individuals for the purpose of providing medical services to needy persons.

(b) All agreements and contracts made by the Administration shall be in writing,

shall have the approval of the Board of Governors, and shall be signed by the President, Secretary, and Medical Director.

Section 5—*Branches.*

(a) A branch office may be established in each county or district in which the Administration operates. Such branch offices shall be under the advisory direction of personnel appointed by the Board of Governors.

(b) Branch offices shall manage the administrative details of the Administration and of medical service plans or arrangements operated within their respective districts or counties under control of the Board of Governors, according to the by-laws of the Administration and the rules and regulations of the plan or arrangements operated in those counties.

Section 6—*Advisory Committees.*

(a) In each county in which the Administration operates a plan or arrangement, there shall be an Advisory Committee. Such committee shall act in an advisory capacity to the Administration. The committee shall be composed of members appointed by the Board of Governors of the Administration upon approval of the component County Medical Societies of The Medical Society of New Jersey. Members of the Advisory Committee shall be appointed for a term of one year or more at the discretion of the Board of Governors. Each committee shall carry out such duties relative to its respective county as shall be designated by the Board of Governors. Each such committee shall contain a majority of medical members.

(b) *Other Advisory Committees.*—Other Advisory Committees may be appointed by and at the discretion of the Board of Governors.

Section 7—*Administrative Offices and Staff.*

(a) The administrative office of Medical Service Administration of New Jersey shall be located as directed by the Board of Governors.

(b) The administrative staff shall be under the direct supervision of the Executive Medical Director and shall consist of the personnel necessary to carry on the routine administrative duties of the Administration.

CHAPTER VII

PARTICIPATING PHYSICIANS

1. Any physician duly licensed to practice medicine in the State of New Jersey pursuant to Chapter Nine Title 45 of the Revised Stat-

utes, who agrees in writing with the Administration to perform the medical services specified in the subscription certificates issued by the Administration, which specified medical services shall be in accordance with accepted practices in the community at the time the service is rendered, and at such rates of compensation as shall be determined by the Board of Governors, and who agrees to abide by the by-laws, rules and regulations of the Administration applicable to participating physicians, and such decisions as may be made by the Board of Governors in connection with matters authorized by law but not specifically covered by said by-laws, rules and regulations shall be accepted as a participating physician.

2. His agreement as a participating physician entered into with Medical Service Administration, may be terminated by written notice to the Board of Governors. Such termination shall not be effective as to any Certificate in force at the time of such notice until the first date thereafter when such Certificates may be cancelled by the Administration. This Agreement for the rendering of service to the end of the current certificate year of each Certificate in force at the date of notice of termination of this Agreement shall not be affected by cessation of the transaction of business by the Administration as a result of action of the Board of Governors, injunction issued by a court of competent authority, legislative act, or by any other exercise of judicial, administrative or legislative authority.

3. He shall have free choice of patient from among the individual beneficiaries applying to him for medical services and may discontinue the treatment of any individual beneficiary according to the code of ethics of the American Medical Association.

4. He shall agree to *accept such fees* as are determined by the Board of Governors.

5. Each Participating Physician will be issued an "Agreement of Participating Physicians," signed by the participating physician and by a representative of the Board of Governors.

CHAPTER VIII

PHYSICIANS' FEES

1. There shall be *included in the minutes* of the meetings of the Board of Governors a record of the approval of payments to be made to participating physicians.

2. No payment to any participating physician shall be authorized by the Board except in accordance with a plan of payments adopted by the Board and recorded in the minutes of a meeting.

3. The plan of payment so approved by the Board shall be determined after consideration of the amount of money available to the Administration for the payment of physicians' fees. Effort will be made to adapt the plan of payment to correspond as nearly as possible to the fees usually paid for similar services by persons of the income class served.

4. The County Advisory Committee will review all physicians' bills referred to them pertaining to their respective counties and approve the fees charged or recommend such charges as they believe are indicated.

5. *Bills* for physicians' services shall be received at the office of the Administration and *paid within thirty days* following the last day of the month in which the bills are received, except where the account is retained for further review by the Administration. Bills for services will not be recognized unless presented within ninety days following the date of service rendered.

6. Fees for physicians' services rendered hospitalized patients will be paid only when such service is rendered while the patient is in a hospital approved by the American College of Surgeons, or the American College of Physicians, or the American Hospital Association, or the New Jersey Hospital Association, or the Hospital Service Plan of New Jersey, or the American Medical Association, or any Component County Society of The Medical Society of New Jersey, or such other hospital as may be approved by Medical Service Administration.

CHAPTER IX

RULES AND REGULATIONS

The Administration shall formulate and adopt such rules and regulations as may be necessary for the proper organization and administration of medical service plans or arrangements to be operated by the Administration. Such rules and regulations shall be a part of these By-Laws and may be changed by a majority vote according to Chapter 4, Section 4 of these By-Laws.

CHAPTER X

GENERAL

Section 1—*Amendments*.—Amendments to these by-laws may be made upon a majority vote of the Board of Governors after presentation at two regular meetings of the Board.

Section 2—*Governing Statute*.—All activities of Medical Service Administration of New Jersey shall be in accordance with the Statutes of the State of New Jersey governing non-profit medical service corporations.

RULES AND REGULATIONS OF THE MEDICAL SERVICE PLAN OF NEW JERSEY

PLAN NO. I

I. DEFINITION

An arrangement by which a selected group of persons may spread the costs of Medical Services by the voluntary pre-payment of subscriptions on an insurance basis.

II. PURPOSES

1. To assist a selected income group of persons to secure Medical and Surgical Services. Such services shall include diagnosis and treatment, certain preventive measures, and the privilege of an annual physical examination. All services shall be rendered by physicians holding full license to practice medicine.

2. To accomplish the above on a basis of voluntary insurance which preserves the present patient-physician relationship and allows the free choice of physicians and patients among the physicians and patients participating under the Plan.

III. PARTICIPANTS

The participants under this Plan shall be of two classes:

1. *Professional Participants* shall be the Participating Physicians of Medical Service Administration of New Jersey.

2. *Beneficiary Participants*. — Beneficiary participants shall be of two classes:

(a) Subscribing beneficiaries shall be those participants who subscribe to Medical Service Administration of New Jersey by the voluntary pre-payment of dues according to these rules and regulations.

(b) Dependent beneficiaries shall be the spouse and dependents of the subscriber acceptable as beneficiaries according to these rules and regulations. Dependent children are children wholly dependent upon the subscriber for support and not over 18 years of age.

IV. MANAGEMENT

The Plan shall be operated and managed by Medical Service Administration as follows:

1. The Board of Governors shall

(a) Determine all policies, rules and regulations governing the operation and management of the Plan.

(b) Appoint a Medical Director and all other administrative officers.

(c) Receive subscriptions from participants and control all disbursements of money so received.

(d) Approve the acceptance of all participants.

(e) Hear the appeal of any participant on matters involving the relationship of the participant with any other participant under the Plan, or his relationship with Medical Service Administration.

(f) Make a decision pertaining to any questions involving the Administration or participants which are brought before it for consideration.

(g) Appoint a County Advisory Committee in each county in which the Plan is in operation.

V. COUNTY ADVISORY COMMITTEE

The County Advisory Committees of Medical Service Administration shall be advisory to the Administration in all matters referred to them by the Administration or Participants of this Plan.

VI. EXECUTIVE MEDICAL DIRECTOR

The Executive Medical Director shall be appointed by the Board of Governors. He shall perform such functions as are delegated by the Administration.

VII. BENEFICIARIES

Subscribing beneficiaries under this Plan will be accepted by the Administration on the following bases:

1. All subscribers shall reside or be employed in the State of New Jersey.

2. An employed person, eligible as a subscriber, may be a single person or head of a family. *The annual income of such subscriber, with additional income allowance for dependents, shall not exceed the amounts indicated in the following table:*

<i>Subscriber</i>	\$1,600.00
<i>First Dependent</i>	400.00
<i>Each Additional Dependent</i> ...	200.00

The term "subscriber's income" shall be interpreted as "Total family income."

3. The Subscriber, at the termination of any contract year, shall become ineligible if his income, or total family income, is in excess of the income limitations stated above. In case the Contract has been renewed, it shall be declared null and void, and subscriptions subsequently accepted by the Administration will be refunded to the Subscriber, after deducting the amount which has been expended by the Administration for payment of Medical Services after the Subscriber became ineligible.

4. No person over 65 years of age shall be accepted as a new beneficiary without having passed a satisfactory physical examination, and then only at the discretion of the Board of Governors.

5. Married women will not be accepted as dependents unless the husbands are also beneficiaries.

6. Applications from ten or more eligible applicants will be considered without medical examinations of applicants or members of applicants' families, provided such applicants are employees of a common employer and constitute in the aggregate 75% of those employees whose incomes fall within the limit defined in paragraph 2 of this chapter. Otherwise a physical examination of applicants and their family members may be required, as hereinafter provided in paragraph 7 of this chapter.

7. Special groups or classifications, other than those groups referred to above, and individuals, will be considered on the basis of a physical examination or on such other basis as may be determined by the Board of Governors.

VIII. SUBSCRIPTION RATES

1. Subscriptions shall be paid to the Administration in advance. Monthly subscriptions shall be due on the first day of each month.

2. A grace period of ten days will be allowed for the payment of monthly subscriptions, and of thirty days for the payment of any annual, semi-annual, or quarterly subscriptions, at the end of which time the agreement of the subscriber will become null and void except as provided in the certificate of agreement of subscriber.

3. Subscriptions as set forth below are payable monthly in advance on the first day of each month beginning with the Effective Date of the contract, at the Head Office of the Administration in Trenton, New Jersey:

<i>Subscribers</i>	\$1.50 per month
<i>First Dependent</i>	1.25 per month
<i>Second Dependent</i>	1.00 per month
<i>Third Dependent</i> .....	.50 per month
<i>Fourth Dependent</i> ....	.50 per month
<i>Fifth Dependent</i> .....	.50 per month

ANNUAL, SEMI-ANNUAL AND QUARTERLY SUBSCRIPTIONS

Subscriptions may be paid annually, semi-annually, or quarterly, if desired, instead of monthly. The annual, semi-annual and quarterly subscriptions shall be respectively 11.4 times, 5.8 times, and 3.0 times the monthly subscriptions. The frequency of subscription payment may be changed on any anniversary of Effective Date, but at no other time.

IX. PHYSICIANS' FEE

Fees paid participating physicians for services rendered beneficiaries will be considered as fees paid in full for the services rendered.

X. BENEFITS

1. Beneficiaries shall be allowed free choice of physician from among the participating physicians.

2. No restrictions shall be placed upon these physicians as to methods of diagnosis employed or treatment rendered.

3. The Administration shall be liable for the payment for services rendered by physicians during periods of absence of a beneficiary from this State on the same fee basis allowed participating physicians of this State under these rules and regulations.

4. The Administration will pay to participating physicians for the necessary medical services rendered by them to beneficiaries, such fees as are determined by the Board of Governors. The fees will be based upon the charges which the Board determines are usually and ordinarily made by physicians, in the certain locality involved, to patients of like responsibility and financial circumstances, for services identical with or similar to those rendered the beneficiary; and further, according to the amount of money available to the Administration for the payment of physicians' fees. Benefits in the form of cash will not be paid by the Administration to any Subscriber except by way of reimbursement to the Subscriber for sums which he has paid to any physician for emergency services rendered for

which the Administration would have been liable.

There shall be in the minutes of the Board of Governors' meetings a record of the approval of payments to participating physicians, and no payment to any participating physician shall be authorized by the Board of Governors except in accordance with a plan of payments adopted by the Board and recorded in the minutes of a meeting.

5. Payment for laboratory procedures will not be made routinely, but shall be made when such payments have been approved by the Board of Governors.

6. The Administration will pay for all types of medical care other than those stated in the section of these rules and regulations, entitled, "Exceptions."

XI. EXCEPTIONS

Payment will not be made for the treatment of the following Medical Services:

1. Functional nervous and mental diseases, and chronic organic nervous or mental diseases, to include all types of insanity.

2. Tuberculosis when the patient is in an institution.

3. Acute and chronic gonorrhea, primary and secondary syphilis, or syphilitic sequelae requiring specific treatment for syphilis.

4. Alcoholism, acute or chronic, and illnesses or injuries resulting from alcoholism.

5. Drug addictions and conditions arising therefrom.

6. All conditions for which patients are entitled to treatment under any workmen's compensation law.

7. Diseases existing prior to the acceptance of the application of the beneficiary.

Payment will not be made for the treatment of the following Surgical Services:

1. Operations for removal of tonsils or adenoids during first contract year.

2. Operations other than for emergency or traumatic conditions during the first contract year.

Payment will not be made for the following Materials or Special Services:

1. Hospitalization.

2. Drugs.

3. Surgical appliances.

4. Nursing care.

5. Maternity care during the first contract year, excepting prenatal care and advice.

6. Specialized services not ordinarily furnished by the general practitioner of medicine, except after approval of the Board of Governors or the Medical Director in the name of the Board.

XII. PREVENTIVE MEDICINE

The Administration also agrees to pay in the aggregate the cost of not more than two office calls on behalf of the Subscriber and of each insured dependent, in each contract year, in connection with (i) diphtheria immunization, (ii) smallpox vaccination, (iii) an annual physical examination and (iv) such other preventive procedures as may be approved in writing by the Board of Governors.

XIII. PARTICIPATING PHYSICIANS

1. Participating physicians shall be the participating physicians of Medical Service Administration of New Jersey.

XIV. WAITING PERIOD

1. There shall be a waiting period of two months during the first contract year before the Administration assumes responsibility for the payment of medical services.

2. The Administration will not pay for Medical Services rendered in the treatment of any illness beginning within two months after the Effective Date. This provision shall not apply to the treatment of injuries effected solely through external, violent, or accidental means during such period of two months.

XV. IDENTIFICATION CARDS

An identification card will be furnished to each beneficiary and participating physician. This card shall be produced by the participant when necessary for identification purposes.

XVI. WAIVER OF LIABILITY

The Administration or its officers shall not be liable for any action taken by a participating physician.

XVII. DEFAULT, TERMINATION, AND REINSTATEMENT

The Administration may terminate any Contract Certificate at the expiration of the contract year upon at least one month's written notice to the Subscriber, and within the provisions contained in the Contract Certificate. In the event that any Contract Certificate becomes null and void through voluntary default in payment of any subscription, the Administration will not pay for Medical Services after date of default.

In the event that any Contract Certificate is terminated by due notice to the Subscriber in accordance with provisions of a Contract Cer-

tificate, the Administration will pay for Medical Service rendered during the year following such termination in connection with any illness for which the beneficiary was receiving medical care at the date of termination, in the same manner, and to the same extent as if this Certificate had been continued in force. When Service has been discontinued because of non-payment of a subscription, the Contract Certificate may be reinstated upon the written request of the Subscriber, subject to the approval of the Administration, but shall cover only such illness as may be first manifested more than ten days after the date of acceptance.

XVIII. APPROVED HOSPITALS

Payment for medical care rendered to hospitalized patients shall be made only if such patients are confined in an Approved Hospital. An Approved Hospital is understood to be one approved by the American College of Surgeons, or the American College of Physicians, or the American Hospital Association, or the New Jersey Hospital Association, or any Component County Society of The Medical Society of New Jersey, or the American Medical Association, or such other hospitals as may be approved by Medical Service Administration.

XIX. WAIVER OF SUBSCRIPTION

Subscriptions shall be deferred and services continued, upon written request of the subscriber, if for reason of illness of the subscriber of one month or more duration, the subscriber is unable to maintain the payment of subscriptions. Payment of deferred subscriptions shall be made as directed by the Board of Governors.

XX. HOW TO OBTAIN SERVICES

1. Apply to any physician who is a participating physician under this Plan.

2. Identify yourself by presenting your identification card and request services of the participating physician as allowed under these rules and regulations or the conditions stated in the certificate of agreement issued to you by Medical Service Administration of New Jersey.

XXI. AMENDMENTS

1. These rules and regulations may be amended or changed at the discretion of the Board of Governors.

2. Notice of all changes and amendments will be mailed to each subscriber not less than seven days prior to date upon which such changes or amendments are effective.

RULES AND REGULATIONS OF THE MEDICAL AND SURGICAL SERVICE PLAN

PLAN NO. II

I. DEFINITION

An arrangement by which a selected group of persons may spread the cost of Medical Services rendered in the care of illnesses and injuries requiring hospitalization, by the prepayment of subscriptions on an insurance basis.

II. PURPOSES

1. To assist a selected income group of persons to secure Medical and Surgical Services. Such services shall include diagnosis, medical and surgical treatment, while the beneficiary is a bed patient in an Approved Hospital, under the care of a private physician. All services shall be rendered by physicians holding full license to practice medicine.

2. To accomplish the above on the basis of voluntary insurance which preserves the present patient-physician relationship and allows the free choice of physicians and patients among the physicians and patients participating under the Plan.

III. PARTICIPANTS

1. BENEFICIARY PARTICIPANTS

a. Beneficiaries.

Beneficiaries will be employed persons with incomes not above \$2000 annually.

b. Annual income shall be determined on the basis of the income of the Subscriber during the twelve months immediately preceding the Effective Date of the Contract and upon each anniversary of the Effective Date as long as the Contract remains in force.

2. PROFESSIONAL PARTICIPANTS

The professional participants will be participating physicians of the Medical Service Administration of New Jersey.

IV. MANAGEMENT

The Plan shall be operated and managed by Medical Service Administration in accordance with the By-Laws of the Administration as stated under the Rules and Regulations.

V. COUNTY ADVISORY COMMITTEE

The County Advisory Committees of Medical Service Administration shall be advisory to the Administration in all matters referred to them by the Administration or Beneficiaries of this Plan.

VI. EXECUTIVE MEDICAL DIRECTOR

The Executive Medical Director shall be appointed by the Board of Governors. He shall perform such functions as delegated by the Administration.

VII. BENEFICIARIES

Subscribing beneficiaries under this Plan will be accepted by the Administration on the following bases:

1. All subscribers shall reside or be employed in the State of New Jersey.

2. Shall be employed persons.

3. No person over 65 years of age shall be accepted as a new beneficiary without having passed a satisfactory physical examination, and then only at the discretion of the Board of Governors.

4. Dependents of subscribing beneficiary shall not be included at present.

5. Applications from ten or more eligible female applicants or ten or more male applicants will be considered without medical examination of applicants, providing such applicants are employees of a common employer and constitute in the aggregate 50% of the female or 50% of the male employees of this employer. Otherwise a physical examination of applicants may be required, as hereinafter provided in paragraph 6.

6. The applications of special groups or classifications, other than those groups referred to above, and individuals, will be considered on the basis of a physical examination or on such other basis as may be determined by the Board of Governors.

7. The Subscriber, at the termination of any contract year, shall become ineligible if his income, or total family income, is in excess of the income limitations stated above. In case the Contract has been renewed, it shall be declared null and void, and subscriptions subse-

quently accepted by the Administration will be refunded to the Subscriber, after deducting the amount which has been expended by the Administration for payment of Medical Services after the Subscriber became ineligible.

VIII. SUBSCRIPTION RATES

1. Subscriptions shall be paid to the Administration in advance. Monthly subscriptions shall be due on the first day of each month.

2. A grace period of ten days will be allowed for the payment of monthly subscriptions, and thirty days for annual and semi-annual subscriptions, at the end of which time the agreement of the subscriber will become null and void at the discretion of the Board of Governors.

3. The basic subscription rate per beneficiary will be as follows:

MONTHLY RATE		SEMI-ANNUAL RATE	
<i>Male</i>	<i>Female</i>	<i>Male</i>	<i>Female</i>
\$.65	\$1.25	\$3.75	\$7.50

ANNUAL RATE	
<i>Male</i>	<i>Female</i>
\$7.50	\$15.00

IX. PHYSICIANS' FEES

Fees paid participating physicians for services rendered beneficiaries will be considered as fees paid in full for the services rendered. No fees will be paid for the care of patients not hospitalized.

X. BENEFITS

1. Payment of physicians' fees to cover the cost of professional care during three-week period of hospitalization.

2. Payment for each necessary professional visit made by a physician to the beneficiary while beneficiary is hospitalized beyond the initial period of three weeks.

3. Payment of cost of necessary diagnostic laboratory and x-ray procedures performed by physicians during hospitalization period for which the beneficiary is personally liable.

4. The Administration will pay Participating physicians for the necessary Medical Services rendered by them to beneficiaries in hospital such fees as are determined by the Board of Governors. The fees will be based upon the charges which the Board determines are usually and ordinarily made by physicians, in the certain locality involved, to patients of like responsibility and financial circumstances falling within the income described under Chapter III, Section 1 a, "Beneficiaries," for services

identical with or similar to those rendered the beneficiary; and further, according to the amount of money available to the Administration for the payment of physicians' fees.

Benefits in the form of cash will not be paid by the Administration to any Subscriber except by way of reimbursement to the Subscriber for sums which he has paid to any physician for emergency services rendered for which the Administration would have been liable.

There shall be in the minutes of the Board of Governors' meetings a record of the approval of payments to Participating Physicians, and no payment to any Participating Physician shall be authorized by the Board of Governors except in accordance with a plan of payments adopted by the Board and recorded in the minutes of a meeting.

The Administration will pay for Medical and Surgical Services rendered to the Subscriber by any fully licensed physician chosen by the Subscriber when the latter is temporarily absent from his regular place of residence or, at any other time, requires emergency service, even though such physician is not a Participating Physician of the Administration. Such payment will be made at the same rate as that allowed to Participating Physicians. A list of Participating Physicians will be furnished upon request.

XI. EXCEPTIONS

1. Payment for diagnostic x-ray examination will be limited to \$15.00 during any one period of hospitalization.

2. Payment will not be made for the following:

- a. Treatment of conditions for which the beneficiary is entitled to treatment under any workmen's compensation law.
- b. Hospitalization.
- c. Drugs, surgical appliances, and nursing care.
- d. Maternity care during the first contract year.
- e. Fees will not be paid for physicians' services rendered in the care of any illness for which the Subscriber is already a patient in a hospital on the day upon which this Contract becomes effective.

XII. WAITING PERIOD

There will be no waiting period except as applied to maternity care. All other benefits become effective on the "Effective Date" of the

contract. This provision may be altered in regard to special groups enrolled on a special basis by the Board of Governors.

XIII. IDENTIFICATION CARDS

An identification card will be furnished to each beneficiary and participating physician. This card shall be produced by the participant when necessary for identification purposes.

XIV. WAIVER OF LIABILITY

The Administration or its officers shall not be liable for any act of the participating physicians.

XV. DEFAULT, TERMINATION AND REINSTATEMENT

The Administration may terminate any Contract Certificate at the expiration of the contract year upon at least one month's written notice to the Subscriber, and within the provisions contained in the Contract Certificate. In the event that any Contract Certificate becomes null and void through voluntary default in payment of any subscription, the Administration will not pay for Medical Services after date of default.

In the event that any Contract Certificate is terminated by due notice to the Subscriber in accordance with provisions of a Contract Certificate, the Administration will pay for Medical Service rendered during the year following such termination in connection with any illness for which the beneficiary was receiving medical care at the date of termination, in the same manner, and to the same extent as if this Certificate had been continued in force. When Service has been discontinued because of non-payment of a subscription, the Contract Certificate may be reinstated upon the written request of the Subscriber, subject to the approval of the Administration, but shall cover only such illness as may be first manifested more than ten days after the date of acceptance.

XVI. APPROVED HOSPITALS

Payment for medical care rendered to hospitalized patients shall be made only if such patients are confined in an Approved Hospital. An Approved Hospital is understood to be one approved by the American College of Surgeons, or the American College of Physicians, or the American Hospital Association, or the New Jersey Hospital Association, or any Component County Society of The Medical Society of New Jersey, or the American Medical Association, or such other hospitals as may be approved by Medical Service Administration.

XVII. WAIVER OF SUBSCRIPTION

Subscriptions shall be deferred and services continued, upon written request of the subscriber, if for reason of illness of the subscriber of one month or more duration, the subscriber is unable to maintain the payment of subscriptions. Payment of deferred subscriptions shall be made as directed by the Board of Governors.

XVIII. HOW TO OBTAIN SERVICES

1. Apply to any physician who is a participating physician of the Medical Service Administration.

2. Identify yourself by presenting your identification card and request services of the participating physician as allowed under these rules and regulations or the conditions stated in the certificate of agreement issued to you by Medical Service Administration of New Jersey.

XIX. AMENDMENTS

1. These rules and regulations may be amended or changed at the discretion of the Board of Governors.

2. Notice of all changes and amendments will be mailed to each subscriber not less than seven days prior to date upon which such changes or amendments are effective.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XIV

February, 1941

No. 2

OLIVER WENDELL HOLMES admonished his medical colleagues to put themselves in the patient's shoes for that would make them more considerate and sympathetic. A physician, who has the gift of graphic description, gives us an objective account of his own sensations during a siege of tuberculosis and a thoracoplasty operation. The tuberculosis specialist as well as the general practitioner will read the account with interest.

TUBERCULOSIS — AN INTIMATE CHRONICLE

In 1932 the author discontinued medical school and entered a sanatorium with the diagnosis of moderately advanced tuberculosis. After more than six years of intermittent curing and working, it was decided to collapse the lung by thoracoplasty. Space permits only that part of the story which has to do with the operation. It was scheduled for a Thursday afternoon. The Monday of that week the patient entered the hospital for the routine laboratory tests. He forced fluids, did this patient, to the extent of three quarts a day and between meals he nibbled on a chocolate bar.

The morning of the operation arrived. The breakfast was a scanty one. The entire right side of the chest was shaved. But the event that he remembers most vividly is the enema, his first. He thought his intestines would break unless that eventuality were prevented by premature death from cramps. And he had prescribed enemata not knowing the sensation they produce.

Lunch consisted of six grains of sodium amytal. Soon he was asleep. Thereafter events grew hazy. He was awakened when the nurses came to dress him for the operation but the awakening was perfunctory. Faintly, he realized that one nurse was donning the boot-hose and another was sticking the hypodermic needle into his arm. He must have slept for he did not recall her extracting it. Nor could he remember anything of his transfer from bed to stretcher, the long ride from one building to another, down one noisy elevator and up another, nor the operation room itself. In fact, the next thing he knew he was back in his room, dusk had settled, a few friends were looking through the door and a nurse was beside him. He felt fine and fully awake.

Just then his doctor entered the room and in his bounding, cheerfully forceful way told him of the good result. "Four ribs practically entirely removed and the lung has collapsed nicely. You probably won't need any more surgery," he added.

That made the patient feel so well that he was tempted to climb over the side guards. The inclination was mental rather than physical and instead, he swallowed a little Vichy and was happy to retain it. Nine p. m. The visitors and well wishers vanished. The nurse pressed out the lights as she withdrew into the corridor, and he was alone.

Well! With nothing to do his mind wandered to his pulse and his fingers were not long in following. He couldn't count it; it was so fast and irregular. But he felt well. Maybe he lay there for an hour when he retched suddenly, forcefully and unexpectedly. He thought his lungs and abdominal organs had popped out through his subclavicular region. He learned then, without aid of a dictionary, what the term exquisite pain means. Strangely enough the wound on which he was lying didn't bother him at all then. For the few subsequent retches he braced himself and instead of having them explode in his chest they were eased over the pharynx with little discomfort.

That first retch seemed to be the signal for the pain to begin. First there was hyperaesthesia around the mouth, probably due to the tightness of the anaesthesia breathing cup. Next, all his teeth began to ache, and that's not hyperbole. They ached all through that first night. Later, his shoulder began to clamor for self assertion. He didn't sleep very well that night, and occasionally, with the assistance of the nurse, he would turn from back to side, or vice versa, over the big bandage, and each time, try as he would to prevent it, the cautious maneuvering always ended in a thud as if he were rolling up or down a curb.

That first postoperative night he had a drenching sweat, and was quite worn out waiting for the dawn. When it came he slept for some three hours and felt wonderfully improved.

That day when the urinal was handed to him at various regular intervals he could void all right, but it was accompanied by no urgency, only by a

sensation of numbness, and he couldn't predict whether he would void an ounce or a pint. The second night the sweat was only dampening. Thereafter they were absent or too mild to be noticed.

The first postoperative days during those few minutes each day when the patient was turned on his unoperated side, dyspnea was almost suffocating. He noticed none at other times.

Although there was some discomfort in the operated shoulder, the pain really didn't come in earnest until the third night. Then his back began throbbing in the region of the wound, and muscles that hadn't been incised were lame. About every half hour he would attempt to relieve the pain by changing his position. This produced more discomfort but little else; for, to the large bandage on his back was now supplemented a shot bag of the general size and shape of a rolled up Sunday newspaper. These two articles effectively kept him in his place.

The night wore on and he was feeling sick and irritable from pain and the lack of sleep; his former resolve to take no pantopon broke down, then and there. It was the first "hypo" that he ever received for the relief of pain. What a great drug it is. In a short time he felt comfortably warm and hazy, a delightful haziness. Gradually, an itchiness appeared all over his skin. He remembered promising himself that he would scratch it later, but before he got to it the night passed, nor does he remember having slept. That didn't annoy him because sleep would have robbed him of that pleasant hazy experience. It was as if, after much work, he had dropped exhausted on the bed, too tired to sleep, and had disintegrated into two people. The one who had pain was unimportant; the important, the conscious one was looking nonchalantly on and not minding it.

On the fourth postoperative day, a small three-pound shot bag was cradled in the right subclavicular region. It later was accompanied by a severe headache in the right frontal and occipital regions. The patient had never been subject to headaches, and the occurrence of headache after wearing that shot bag, and a larger one, was noticed too frequently to be mere coincidence. There was a relationship between them.

Saturday, two days postoperatively, he had his second enema. The following Monday he had his last. They confirmed his original opinion of them. They gripe—and that's not slang.

The big bandage was removed one week postoperatively, as were the skin sutures. The scar was a nice one. Naturally he was interested in trying

to move his arm. There were definite weakness, soreness and limitation of motion, but he could move it surprisingly well. He roughly estimated it to have maintained about three-fourths of its normal function in all directions. Thereafter, each day, he grabbed hold of the steel bars at the head of the bedstead and worked his arm progressively further along it. Within a month postoperatively there were only stiffness and weakness, without any real limitation compared with the other side. Within six weeks all the stiffness had disappeared, and, except for definite weakness, the arm was quite normal. The weakness was especially marked when he held the arm out in front of him, particularly when he elevated it above the shoulder.

Four days postoperatively, with the aid of a toe hold on the foot of the bedstead, he was able to sit up unassisted, but he didn't feel quite well until ten days postoperatively.

Six weeks postoperatively the collapse as shown on the X-ray film appeared to be excellent and it was decided that one stage of four ribs was all that he needed. The following week he returned home (and with the aid of a diary began to write a few notes regarding the operation).

One day he dropped his pencil under the bed and in an effort to regain it had to get down on his knees and reach forward, upward and outward so that the scapula on the operated side was rotated far forward and elevated. He retrieved the pencil all right but the angle of the scapula somehow climbed over the fifth rib, and on its way back nestled inside the rib leaving him in little pain but greatly embarrassed. Slowly, he manipulated the scapula back into place. The scapula hasn't locked since, but when he hunches his shoulder far upward and forward he can still feel a bumping of the angle of the scapula as it goes over the fifth rib.

Before the right pectoral muscles had regained much tone he could place his fingers in the depression left by the excised ribs and feel the muscles on the pleural side of the scapula, and could push the scapula backwards. Now, six months after the operation, this can no longer be done.

As long as four months postoperatively, the patient could still feel very occasionally a vague pinching in the region of the scar and thought perhaps it was due to regeneration of the nerves.

Your chronicler hopes to continue to observe the result of this operation, and report more fully on its outcome after sufficient time has elapsed to properly evaluate its benefits and shortcomings.

Tuberculosis—An Intimate Chronicle by John A. O'Hale, *Amer. Rev. of Tuber.*, Nov. 1940.

RULES AND REGULATIONS

OF

THE FARM SECURITY PLAN

PLAN NO. III

I. DEFINITION. An arrangement sponsored in co-operation with the Federal Farm Security Administration, by which rehabilitation clients of Farm Security Administration may receive necessary medical care, and by which the physicians rendering such care may be reimbursed for their services.

II. PURPOSES. To assist low-income farm families in New Jersey who are rehabilitation clients of Federal Farm Security Administration, to secure medical and surgical services. Such services shall include medical care in the office and home as is ordinarily rendered by a general practitioner of medicine, the treatment of minor injuries and fractures not requiring hospitalization.

To accomplish the above purposes on the basis of voluntary insurance which preserves the present patient-physician relationship and allows free choice of physicians and patients among the physicians and the patients participating under this plan.

III. PARTICIPANTS.

A. Beneficiary Participants will be those low-income farm families who are receiving rehabilitation or tenant purchase loans as clients of Farm Security Administration.

B. Professional Participants will be the participating physicians of Medical Service Administration of New Jersey.

IV. MANAGEMENT. The Plan shall be operated and managed by Medical Service Administration, in accordance with the By-Laws of the Administration, and with these Rules and Regulations.

V. COUNTY ADVISORY COMMITTEE. The County Advisory Committees of Medical Service Administration shall be advisory to the Administration in all matters referred to them by the Administration or Beneficiaries of this Plan.

All physicians' bills referred to County Advisory Committees will be forwarded to the office of Medical Service Administration of New Jersey not later than the twentieth day of each month.

VI. THE MEDICAL DIRECTOR. The Medical Director shall be appointed by the Board of Governors of the Administration. He shall represent the Board of Governors, and perform functions in accordance with the By-Laws of the Administration.

VII. BENEFICIARIES. Subscribing beneficiaries of this Plan shall be accepted by the Administration on the following bases:

1. All beneficiaries shall reside in the State of New Jersey.
2. All beneficiaries shall be members of families

who are receiving rehabilitation or tenant purchase loans as clients of Farm Security Administration.

The term *family* is defined as the husband and wife, and all members of the family living in the same household and dependent upon the head of the house for support. An elderly parent or other family member receiving from any source more than \$15.00 per month is to be considered not dependent and, therefore, obliged to pay the single rate for participation if desired. Old age assistance clients entitled to payment for medical services under old age assistance plans in this State shall not be entitled to benefits under this Plan.

VIII. SUBSCRIPTION RATES.

Annual rates:

* Single person	\$12.00
Man and wife	16.00
Family of three	17.00
Family of four	18.00
Family of five	19.00
Family of six or more	20.00
Each confinement case—an additional	10.00

Each home call requested after 10 p. m.—an additional \$1.00 to be paid directly to the physician by the participants.

IX. PHYSICIANS' FEES.

A. Medical Service Administration of New Jersey shall place all dues received under this program in a special fund to be administered separately from other Plans operated by the Administration.

B. Five per cent of all dues shall be deducted by the Medical Service Administration of New Jersey for administration expenses.

C. After deduction of five per cent for administration, the remainder of the fund and annual dues received subsequently shall be divided into twelfths, with one-twelfth being available for the payment of physicians' bills each month.

D. A fee schedule approved by the County Advisory Committees and the Board of Governors of the Medical Service Administration, according to the By-Laws of that organization, shall be used as a basis for fees under this Plan.

E. Physicians shall submit monthly bills for services to Medical Service Administration, 143 East State Street, Trenton, using a bill form prepared for the purpose by Medical Service Administration of New Jersey. Bills shall be in the hands of the Administration by the tenth of each month for services rendered during the previous month. Bills received late shall be reduced by one-third, and added to the bills for the next month.

F. The county advisory committee of physicians shall audit bills rendered by the Administration, and submit them by the 20th day of each month to Medical Service Administration of New Jersey, which will then pay approved bills as follows:

1. Bills will be paid in full if there are sufficient funds available for the month in question.

2. If funds are insufficient to pay the bills in full, all available funds for the month will be distributed to the physicians on a pro rata basis.

3. Payment for obstetrical cases shall be as follows: The physician to receive \$10 of his fee without any reduction (the \$10 extra deposited in advance by the family with the Medical Service Administration—see VI D) and the remainder of his fee from the regular fund in the manner provided in (1) and (2) above.

4. Any surplus remaining after bills for a given month are paid shall be held over to the end of the program's fiscal year, when any accumulated surplus will be applied on a pro rata basis against any unpaid balances still owed the participating physicians.

5. Any surplus remaining at the end of the fiscal year after all payments have been made as above, to be carried over in the special fund for such use the following year as Medical Service Administration may decide or, if the program were discontinued, to be distributed to the participating families on a pro rata basis in proportion to the total dues paid by each family during the year.

6. At the end of each fiscal year, after all payments have been made as above, the bills shall be written off as having been paid in full.

X. BENEFITS shall consist of:

A. Medical care in the office and home such as is ordinarily rendered by a general practitioner of

medicine, including obstetrical care (with prenatal and post-natal care); the treatment of minor injuries and fractures not requiring hospitalization; and the provision of ordinary drugs and dressings such as the physician himself may be accustomed to dispense or employ in the office or home without additional cost to the patient. In chronic cases, office or home calls will be limited to one a week, except for some acute exacerbation of the disease.

B. Preventive services, including (1) annual health examination of any participant on a selective basis when the physician considers it advisable; (2) desirable immunization and other prophylactic measures not available through the county or state public health program, the participant to pay the cost of materials not furnished free by any health department, and the physician to charge against the fund the regular office call fee agreed upon.

XI. LIMITATIONS. Payment will not be made for the following materials or special services:

1. Drugs.
2. Surgical appliances.
3. X-rays other than minimum x-ray service necessary to establish diagnosis in traumatic cases.
4. Nursing care.
5. Care of hospitalized cases.
6. Cost of hospitalization.

XII. WAITING PERIOD. There shall be no waiting period. All benefits become effective on the Effective Date of the Contract.

XIII. IDENTIFICATION CARDS. An identification card will be furnished to each beneficiary. This card shall be produced by the beneficiary when necessary for identification purposes.

PARTICIPATION

Your support is requested. A copy of "Agreement of Participating Physician" is enclosed for your signature. Return to 143 E. State Street, Trenton, N. J.

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Founded July 23, 1766

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TELEPHONE 5156

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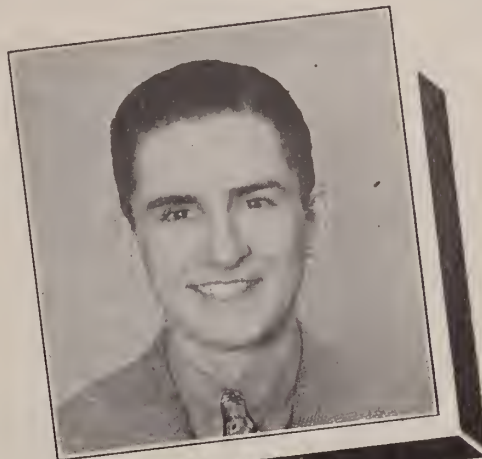
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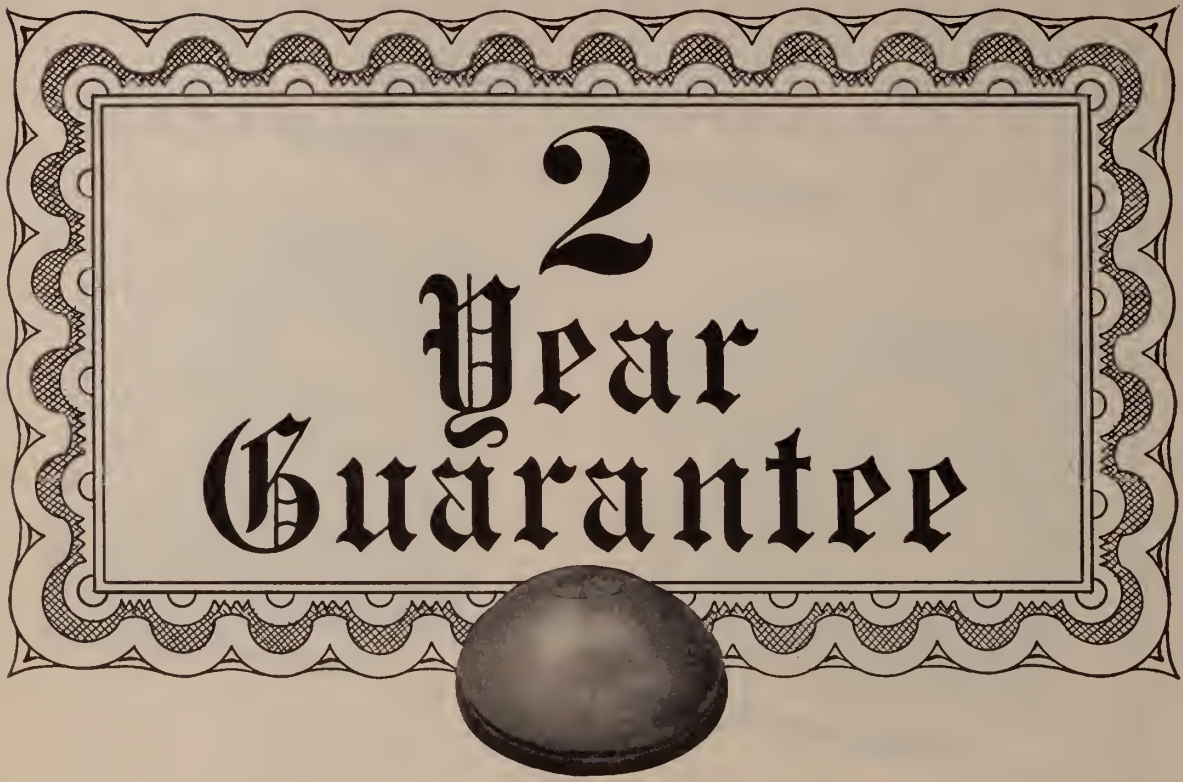
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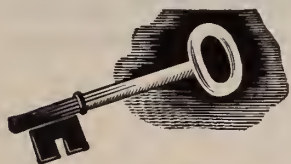
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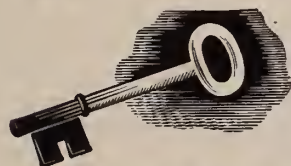
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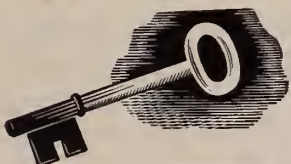
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II. Development of the Tin Container

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As containers, Appert suggested glass containers sealed by corks; the reason given is that glass is the "matter most impenetrable by air" (1). In 1810, one year after Appert's discovery was announced, Peter Durand, an Englishman, patented a procedure very similar to Appert's, which covered the use of a variety of containers, among them "vessels of tin (tin-plated iron)." From that time forward, the use of tin-plated containers rapidly progressed.

Commercial canning began in America about 1819. In 1825, Kensett and Daggett, two pioneers of canning in this country, received an American patent covering the use of tin-plated containers. Shortly thereafter, the name "tin can" was coined from the abbreviation of the formal name, "tin cannisters."

The story of the development of the tin can in America is an absorbing one which has been related in more detail elsewhere (2, 3, 4). By the time of the war between the States, the "hole and cap" type of can had been evolved. About 1890, can-making machinery was introduced to replace the

older hand-manufacturing operations whereby a skilled artisan could produce about 6 cans per hour. Modern can-manufacturing lines operate at speeds as high as 350 cans per minute.

The first three decades of the current century witnessed the development of machinery to make the modern type or "sanitary style" can now universally used for fruits, vegetables, and a wide variety of other products. The past ten years have brought vast improvements in the tin plate from which cans are made. Not long ago, almost any type of sheet steel was considered satisfactory. Today plate for cans must comply with rigid physical and chemical specifications established by the Research Laboratory of the can manufacturer.

As far as can be determined, tin containers were first introduced to avoid breakage which was experienced with the glass containers proposed by Appert. The other desirable characters of the tin container for foods were not fully appreciated at first; among these advantages should be mentioned its rapid rate of heat transfer, its low weight in relation to its capacity, and its opacity to light. Nor was the importance which the tin can has attained in our national life fully appreciated until world developments caused America to pause and take inventory. Only then was it generally realized that from its humble start 130 years ago, the tin can has risen to become an indispensable article in our modern civilization.

AMERICAN CAN COMPANY

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REFERENCES

- | | |
|--|---|
| (1) 1811. The Art of Preserving. M. Appert, Black, Parry and Kinsbury, London. | (3) 1937. Appertizing. A. W. Bitting, The Trade Pressroom, San Francisco. |
| (2) 1937. The Canning Clan. E. C. May, The Macmillan Co., New York. | (4) 1940. The National Geographic Magazine, November, p. 659. |

We want to make this series valuable to you, so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned-foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles. This is the sixty-eighth in a series which summarizes, for your convenience, the conclusions about canned foods reached by authorities in nutritional research.



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33 Central Ave.

NEWARK—Cont'd.
J. C. REISS
10 Hill St.
CHARLES STEIGLER
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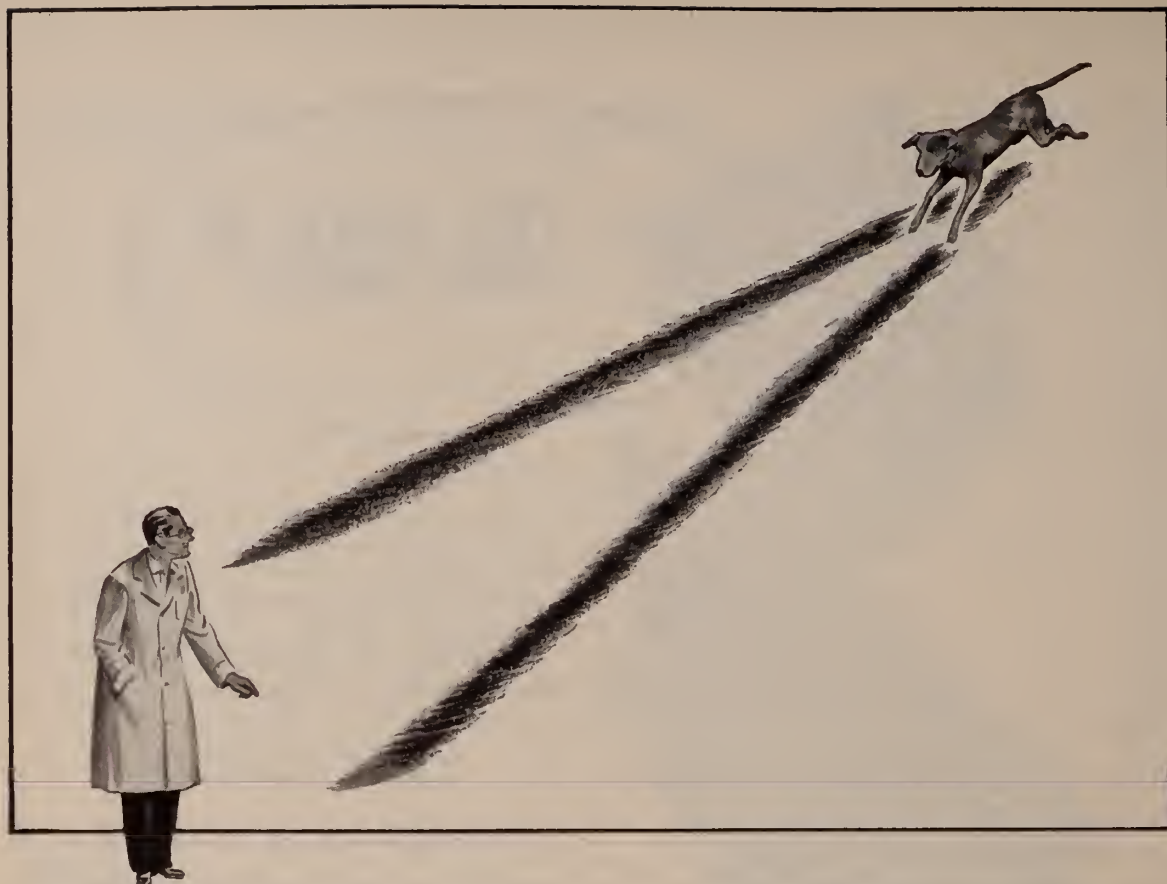
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The Conquest of Pellagra

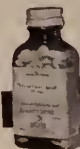
In the annals of medical science few discoveries have been more notable than that of the dramatic role nicotinic acid plays in the treatment of pellagra.

Although earlier research workers had devoted much effort to the problem, it was Dr. Joseph Goldberger and Dr. W. H. Sebrell who, in 1930, supplied the necessary clue by their discovery of the beneficial effect of liver therapy in this deficiency disease.

Thereafter progress was rapid on several fronts, with major credit for the final victory due largely to Dr. C. A. Elvehjem for his identification of nicotinic acid or nicotinic acid amide with the black-tongue preventive factor. It was his

patient, tireless work with great batches of liver extract that narrowed the search to the few vital crystals which proved to be nicotinic acid. He and his co-workers at the University of Wisconsin—Madden, Strong, and Woolley—fed a few of these crystals to a mongrel dog suffering from black-tongue. In less than a day the symptoms had begun to disappear. Thereafter it remained for Dr. T. D. Spies in Birmingham, Alabama, and others, to apply nicotinic acid to their clinical work on humans, with what result the world knows.

Nicotinic Acid (Upjohn) is available in tablet form in 20, 50, and 100 mg. size, in bottles of 100 and 1000.



KALAMAZOO

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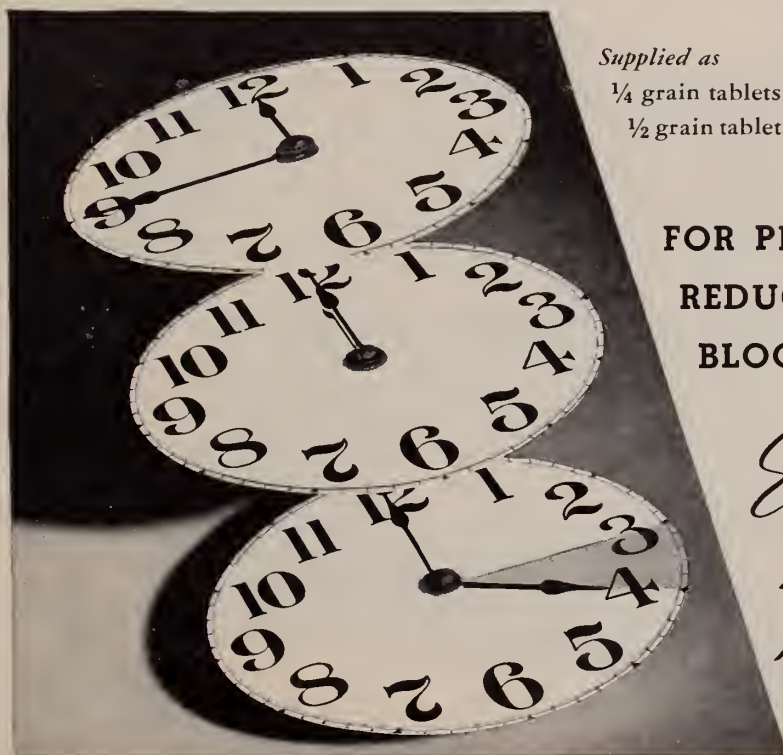
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Erythrol Tetranitrate Merck

The increased prescription use of Erythrol Tetranitrate Merck which followed the recent introduction of the new, improved tablets has permitted a reduction in the price of this effective vasodilator.

The special value of Erythrol Tetranitrate Merck in the treatment of arterial hypertension and angina pectoris lies in the duration of its action. As a result of this prolonged activity, it is possible, by careful adjustment of dosage in the individual case, to obtain sustained vasodilatation.



Supplied as

$\frac{1}{4}$ grain tablets...Vials of 50 Bottles of 500

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**FOR PROLONGED
REDUCTION OF HIGH
BLOOD PRESSURE**

*Erythrol
Tetranitrate
Merck*

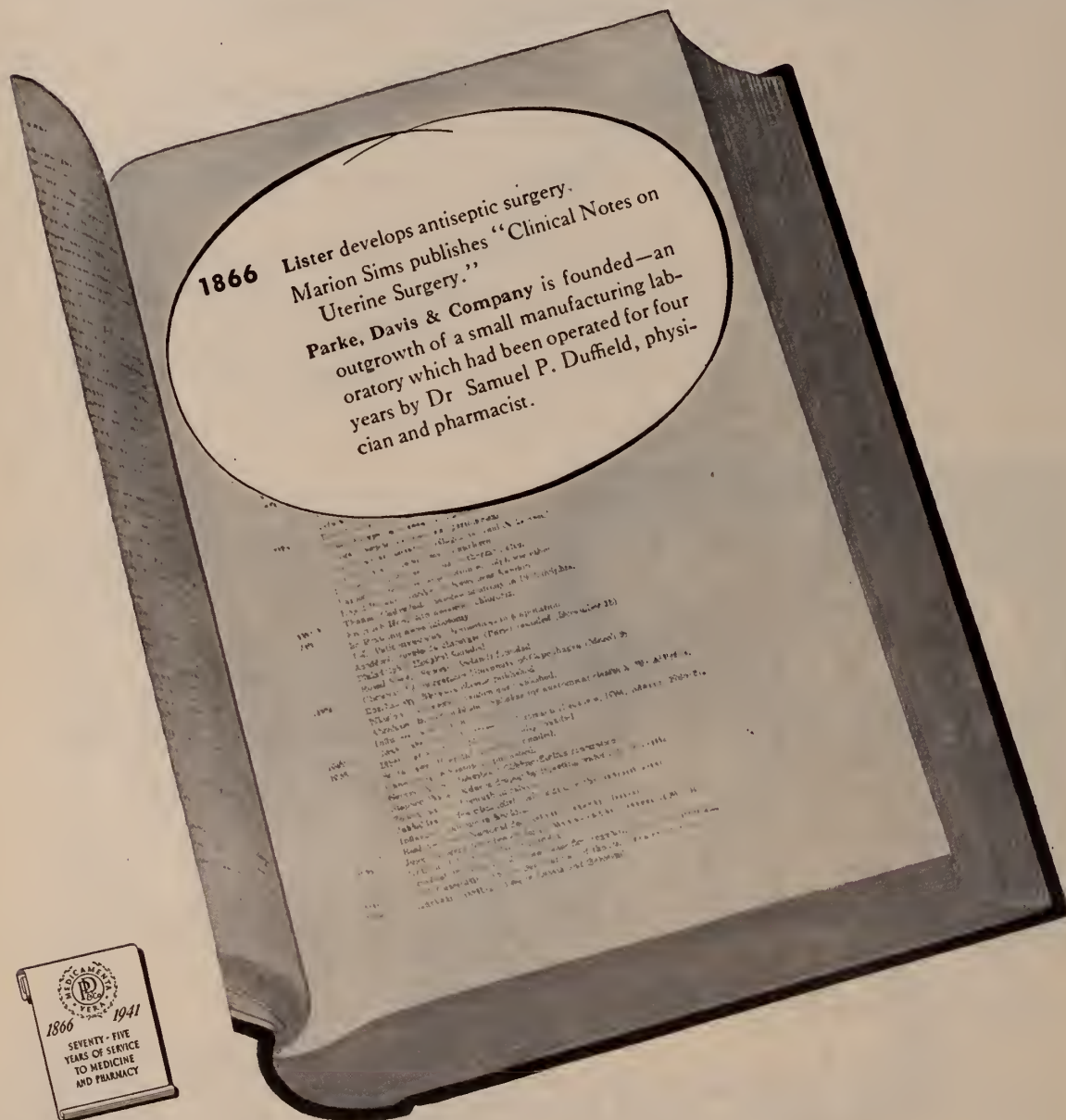
The vasodilator action of Erythrol Tetranitrate Merck usually begins within about fifteen minutes after administration and persists for a period of 3 to 4 hours. This effect of prolonged vasodilatation, beginning within a short time after oral administration, is not obtained with any other of the commonly used nitrites.

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Every practitioner has them — patients who are coming down with colds, but who refuse to go to bed.

While Benzedrine Inhaler cannot be expected to cure these difficult patients, its use will give them marked comfort. Its vapor, diffusing throughout the upper respiratory tract, rapidly relieves congestion and thus promotes ventilation and drainage.

NO ATOMIZERS NO LIQUIDS
NO TAMPONS NO DROPPERS

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A VOLATILE
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PHILADELPHIA, PA.**

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Each tube is packed with amphetamine, S. K. F., 325 mg.; oil of lavender, 97 mg.; menthol, 32 mg. Benzedrine is S. K. F.'s trademark, Reg. U. S. Pat. Off.

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Another important chapter **IN ANTIBACTERIAL CHEMOTHERAPY!**

• Sulfathiazole constitutes an additional triumph of chemotherapeutic research which has already proved of great value to clinical medicine.

PNEUMOCOCCUS INFECTIONS . . . Thousands of cases of pneumococcus pneumonia have responded with dramatic promptness to Sulfathiazole. In comparison with its pyridine analogue, Sulfathiazole is less likely to cause serious nausea or to provoke vomiting.

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HOW SUPPLIED: Sulfathiazole-Winthrop is supplied in tablets of 0.5 Gm. (7.72 grains); also (primarily for children) in tablets of 0.25 Gm. (3.86 grains).

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In Excessive Loss of Water, Chlorides and Base from Sweating or Other Causes

In dehydration such as occurs in excessive vomiting, prolonged diarrhea, marked diuresis and excessive sweating, the use of Saratoga Geyser and Coesa Waters is of value. They provide for the replacement of the fluid, chloride and base. It is noteworthy that the concentration of salts in both these Waters is close to that in physiological saline.

The use of these natural mineral waters is of value in mineral replacement therapies following either diet deficiency or any of the above conditions. The richness of mineralization is recorded in the accompanying analyses. Geyser Water is particularly palatable because of its supersaturation with CO₂. It is a refreshing beverage, as well as of medicinal advantage.

People who indulge in sports of an active nature will be invigorated by it. In competitive sports where perspiration is intense, this is particularly evident.

The Waters and their Internal Use are the subject of discussion in Spa Publication Number 9. . . . A copy will be sent on request addressed to W. S. McClellan, M.D., Medical Director, Saratoga Spa., 159 Saratoga Springs, N. Y.

Analysis of the Three Waters

(MINERAL PARTS PER MILLION)

Hypothetical Combinations	Geyser Water	Hathorn Water	Coesa Water
Ammon. chlorid	48.25	59.10	33.30
Lithium chlorid	21.07	64.49	46.43
Potass. chlorid	361.91	789.54	714.86
Sodium chlorid	2,010.48	8,594.84	4,233.14
Potass. bromid	9.23	160.00	13.90
Potass. iodid	1.10	4.80	1.36
Sodium sulphate	None	None	None
Sod. metaborate	Trace	None	Trace
Sodium nitrate	Trace	Trace	Trace
Sodium nitrite	Trace	Trace	Trace
Sodium bicarb.	2,213.78	424.71	1,331.15
Calcium bicarb.	1,829.14	3,380.84	2,519.74
Barium bicarb.	16.67	25.65	25.00
Strontium bicarb.	Trace	Trace	Trace
Ferrous bicarb.	9.94	40.07	5.86
Magnes. bicarb.	753.89	2,244.88	1,186.57
Alumina	7.14	4.98	6.37
Silica	19.49	14.40	12.80
Total	7,284.00	15,808.30	10,130.48

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showing the influence of hygroscopic agents in cigarettes on the membranes of rabbits' eyes.*



TYPICAL 1 + EDEMA

on instillation of smoke solution from Philip Morris Cigarettes. (Note extension of edematous nictitating membrane over the bulb.)



TYPICAL 3 + EDEMA

on instillation of smoke solution from ordinary cigarettes. (Note nictitating membrane more extended. Bulbar conjunctiva is raised and palpebral conjunctiva is edematous and redundant.)

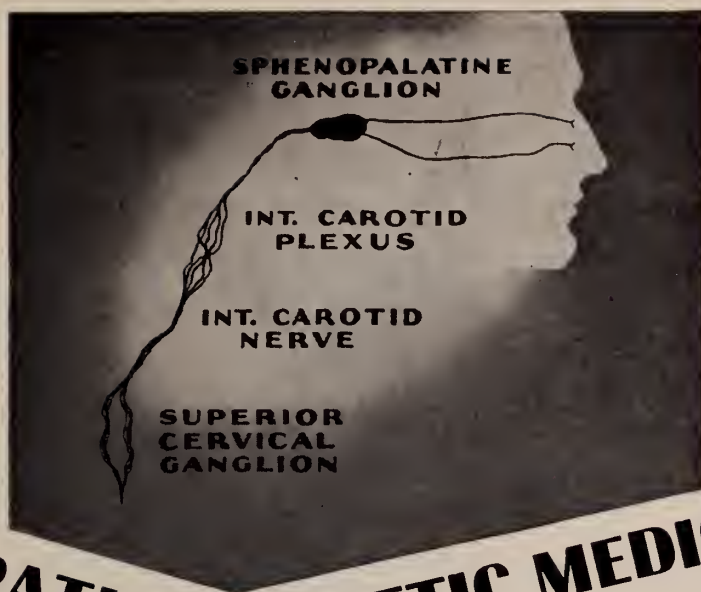


NORMAL

CLINICAL CONFIRMATION:** When *smokers* changed to Philip Morris, every case of irritation of the nose and throat due to smoking cleared completely or definitely improved.

**Proc. Soc. Exp. Bio. and Med.*, 1934, 32, 241-245

***Laryngoscope*, 1935, XLV, No. 2, 149-154



SYMPATHO-MIMETIC MEDICATION

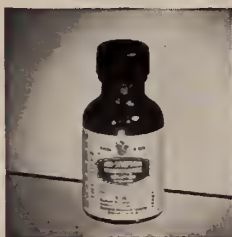
THIS powerful vasoconstrictor shrinks engorged mucous membranes rapidly, with more prolonged action than ephedrine and with less toxicity in therapeutic dosage.

NEO-SYNEPHRIN HYDROCHLORIDE

(laevo- α -hydroxy- β -methyl-amino-3 hydroxy ethylbenzene hydrochloride)

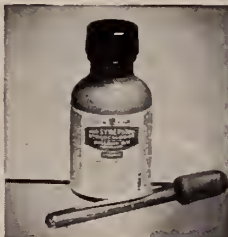
The sympatho-mimetic, vasoconstrictor action of Neo-Synephrin Hydrochloride makes it a widely useful drug both for local use in colds and sinusitis, and for subcutaneous use in acute hypotension.

DOSAGE FORMS—For Intranasal Application



SOLUTION

$\frac{1}{4}\%$ and 1% in 1-oz. bottles



EMULSION

$\frac{1}{4}\%$ in 1-oz. bottles



JELLY

$\frac{1}{2}\%$ in applicator tubes

For Acute Hypotension

One Per Cent Sterile Solution—15 cc. rubber-capped vials.



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EPHEDRINE INHALANTS, LILLY



Topically applied to inflamed nasal mucous membrane, ephedrine relieves congestion and facilitates drainage.

Inhalant Ephedrine (Plain), Inhalant Ephedrine Compound, and Ephedrine Jelly, through many years of use, have proved their worth in increasing nasal ventilation during respiratory infections.

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THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

PUBLISHED MONTHLY SINCE SEPTEMBER, 1904
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UNDER THE
DIRECTION OF THE
COMMITTEE ON PUBLICATION



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FRANK OVERTON, M.D., Dr. P.H.

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EXECUTIVE OFFICER—LEROY A. WILKES, M.D.

EXECUTIVE ASSISTANT—NORMAN M. SCOTT, M.D.

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VOL. XXXVIII, No. 2

FEBRUARY, 1941

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Single Copies, 30 Cents

EDITORIAL Public Relations

One outstanding objective of the present Administration is the promotion of our relations with the public. To do this we need mutual understanding with other agencies interested in human welfare. We need their confidence and respect; and they want ours.

Our Public Relations Committee is the liaison between the medical profession and the community. Part of its function is to inform the public of the aims and policies of The Medical Society of New Jersey. This it does through its Speakers' Bureau, its exhibits, and its newspaper releases.

Never before in the history of medicine has there been sharper need for sustained effort to protect the doctor while meeting the economic limitations of the patient. This problem throws into more meaningful focus the work of promoting our relations with the public. We must tell the public of our attitudes towards health problems; and we must be their leader in all movements towards better health. Although American medicine is under indictment, we can not weaken in this duty to the public. On the contrary, by our behavior towards community problems, we can put the American doctor back where he has always been, and always belonged—the object of universal respect, and acknowl-

edged as a practitioner dedicated primarily to the service of mankind. In this crusade, The Medical Society of New Jersey is vigorously engaged.

An army composed of officers only is as inefficient as one composed only of privates in the ranks. The County Society is therefore an important element in organized medicine. On the one hand, it trains its members to make intimate contacts with local health and welfare organizations; and on the other hand, this practical service gives the members an understanding of human needs which qualifies them for positions on the official list of officers and committees of the State Society.

The most vital link in the chain of organized medical service is the individual practitioner of medicine. By his daily work and his intimate contacts with the "public", he is the most powerful bulwark we have against sudden, ill-advised, radical changes in medical practice.

Every organized experience and discipline makes headlines in its field. This we too must do, if we are to survive and practice our calling in the "American Way".

WATSON B. MORRIS, M.D.,
President.

Time for Action

Eternal vigilance is still the price of liberty: liberty to practice your profession without being harrassed by cultists. The McClave Medical Practice Act is the bulwark of high medical standards in New Jersey. But the forces which would release substandard cultists to prey on the sick are not so easily suppressed. Daily they snipe at the medical profession, clamoring for repeal of the McClave Act. With a great show of indignation, they howl at giving doctors a "monopoly" to treat the sick. Do they, one wonders, object to granting ships' officers a monopoly to navigate the ship? They protest the ban on doctors' advertising. If a "healer" broadcasts an announcement that he can cure cancer for a thousand dollars or restore eye-sight for a hundred, why that, they say, is only the good old American custom of trade-plugging: to stop a practitioner from thus hawking his wares is "Unamerican". And they object, most certainly they object, to the requirement that chiropractors must pass an examination in human anatomy.

What does all this mean to you? It means that you must be eternally vigilant lest, through your inattention, the McClave Act be repealed, and hordes of untrained cultists be invited to mulct the people of New Jersey. It means that those interested in debasing medical standards will exercise every wile and artifice available to scuttle the McClave Act.

Already the assault has begun. A Mercer County assemblyman has just introduced a McClave Act repealer. The sponsor of the bill is Dr. Charles Browne, himself a licensed physician. In advocating measures to lower the standards of education required of healers, Dr. Browne, is, of course, within his rights. He has a right to introduce any kind of bill he wants. If he feels that asking healers to prove their knowledge of human anatomy is an invasion of their rights, that too is his privilege. Indeed, if he introduced a bill to refuse a

medical license to any one who could read or write, that too would be his privilege. And for the medical profession to resist such proposed legislation is not only their right; it is their duty. For each physician has sworn an oath to "Carry out the regime for the benefit of the sick, to keep them from harm and wrong". And to fight any lowering of medical standards is but to comply with that oath.

The Browne Bill has already slipped into the legislative hopper. Every doctor in New Jersey has a duty to call the hazards of this bill to the attention of every legislator, editor, and public-spirited citizen whom he knows. More than that, every physician owes it to himself and his patients to understand the provisions of the McClave Act, and to be able to point out why the Act is a real charter of human health.

If we doctors remain in ivory-turreted silence, while advocates of substandard medical education and commercialized medical practice shout their message from the housetops, win the support of sensation-seeking newspapers, and fling unchallenged calumnies at the medical profession, then, in truth, we shall lose the battle . . . and lose it by default.

As a practitioner, you are on the firing line. Facts, truth, information—these are your weapons. You can get the facts about the McClave Act, about the proposed repealer, about the effects of educational standards on public health from the office of your Medical Society. You can't fight without this ammunition. And we have it for you. Are you going to send for it, use it, and make a firm stand for your hard-earned rights? Or will Medicine again lose to opponents armed only with their own ballyhoo and our own indifference?

It is time for action, and you are one of the actors. Your cue has been sounded. The next move is yours.

CHARLES M. ROBBINS, M.D., Chairman
Public Relations Committee.

Leadership and Job Satisfaction

Industry in recent years has become intensely interested in studying two important problems:

- I. "Job Satisfaction"—for the individual.
- II. "Leadership"—its essentials and practice.

The first of these objectives is understood and appreciated by the most individualistic among physicians. The second intrigues the interest and efforts only of those physicians whose vision and practice extend beyond the needs of the individual to those of specialized groups composing our communities.

The essential tools of *leadership* are authority and award. The proper use of these distinguishes the recognized and approved *leader* who will be willingly and gladly followed.

Job satisfaction for the individual is impossible in any organized effort under bad leader-

ship. Our satisfactions result from accomplishment, and must be shared and approved by others to be most complete. The wise leader recognizes this fact and utilizes every opportunity to reinforce with judicious praise the satisfactions of the individual which rightly come as a reward to the competent and conscientious workman who continually puts forth his best thought and effort.

Medical leadership must be *earned*. It is not an inherent right of any physician who has not demonstrated his ability as a leader. Proven ability in leadership and accomplishment among medically trained graduates unquestionably provides the most effective and approved type in meeting health problems wherever they occur.

LEROY A. WILKES, M.D.

Fitness for Military Service

No longer may an army be shanghaied from the streets and lodging houses, placed in a front line, and driven into battle by a rear guard of seasoned troops. Any man will rush toward the enemy when he knows that it is still more dangerous to try to run away. A modern army requires men whose physical stamina and mental poise are unquestioned. But there is still room in civil life for men who cannot conform to the high physical, mental, and moral standards of the army.

There will always be wide variance in the inherent degrees of physical development and moral stamina among the young men of the nation, no matter how much effort is expended on health work. Only those of the highest standards are now acceptable to the army. But for every soldier, eighteen men are required to give honorable service in civil life in order to support the one in the field.

Numerous articles are already being written deploring the proportion of drafted men who are found unfit for strenuous service in the army. There are fewer criticisms of the pro-

portion of those who cannot meet the still higher standards required by the navy, where there is no room for a weakling, even in the boiler room and the manual labor department of a warship. There are practically no criticisms at all of the extremely high standards required of recruits in the aviation branch of the national defense.

The psychological state of a prospective recruit is also to be considered, even though it is often difficult to evaluate. Some recruits who are physically fit are temperamentally unable to adjust themselves to army life, and remain in reconstruction departments of the training camp throughout the whole period of the war, and afterward spend the rest of their lives at government expense in hospitals where all their needs, physical and social, are supplied. The psychologist and the psychiatrist have extremely important and responsible positions on an induction board, for in the quiet time of peace it is often difficult to detect a weakness of mind or character which will show itself in an acute form in a strenuous campaign.

The American Medical Association and New Jersey

A pamphlet issued by the American Medical Association, dated November 25, 1940, credits New Jersey with 4,970 *practicing* physicians.

This pamphlet also credits New Jersey with 3,875 subscribers to the A. M. A. Journal,—or 78 per cent of the practicing physicians.

The pamphlet also gives the figures for all the other States, the highest percentages in the larger States being as follows:

New Jersey	78
New York	66
Pennsylvania	66
Massachusetts	65
Illinois	64
California	64
Michigan	61
Wisconsin	60

The A. M. A. Directory of 1940, page 8, credits New Jersey with a total number of 5,813 physicians, but it does not use the qualifying word *practicing*.

No one seems to know how many M.D.'s are living in New Jersey but are engaged in other work, or are not practicing medicine. However, taking the figures of the A. M. A., the New Jersey physicians are now even more loyal to the A. M. A. than in 1934, when New Jersey led all the other States in the percentage of physicians subscribing to the A. M. A. Journal—65 per cent (N. J. Journal, October, 1934, page 554).

The Appeal of the Medical Service Administration

The Medical Service Administration is designed as a method of enabling single persons with yearly incomes under \$1,800 to obtain medical services, particularly in catastrophic illness in which the expense is abnormally high, and the income is nothing. It is not a free service, but is a form of insurance under the supervision of the State Department of Insurance. The income of families may be higher.

The theory of the Administration is that a severe illness, like a fire or hurricane, is a rare and unexpected event in the life of any particular individual; but it is sure to afflict a few persons in any large group. The Administration is designed for the benefit of persons who have an instinctive appreciation of thrift, and are willing to set aside a small sum each week or month to be placed in a common fund and used in paying the bills of the doctor and the hospital. There is a basic charge for each insured workman, and a graded charge of lesser amount for each dependent person in the family.

The group feature of the Administration is one of its strong points; for the news of financial benefits actually received will travel as fast as that of a winning lottery ticket, and will be

a potent argument for others to take up the insurance.

It is expected that the project will be especially popular among large groups of workmen, as in factories and stores. It should also appeal to isolated workmen on farms, and small industrial plants in rural districts where the spirit of economy and thrift is more potent and intense than in the cities.

The written agreement of at least fifty-one per cent of the members of a County Medical Society will be required before the Administration can function. This proportion is required in order that a sufficient number of physicians may be available so that a patient may have a wide choice of the particular physician whom he wishes to employ. The system will encourage a participating member to choose a family doctor, and to call him in preference to any other physician.

The system will also encourage a self-respect which is lacking in all impersonal forms of relief, such as are dispensed by the city or county physician who happens to be sent to a particular case.

The details of the Medical Service Administration are contained in the supplement to this issue of The Journal.

ORIGINAL ARTICLES

THE PREVENTION AND TREATMENT OF POSTOPERATIVE PULMONARY COMPLICATIONS

By GEORGE N. J. SOMMER, JR., M.D., Trenton, N. J.

From the Department of Surgery, St. Francis Hospital, Trenton, N. J. Read before the Section on Surgery at the 174th Annual Meeting of The Medical Society of New Jersey, in Atlantic City, June 5, 1940.

The important pulmonary affections following surgical operations are atelectasis, pneumonia, and embolism. With the many efforts being made to diminish surgical morbidity and mortality, the postoperative pulmonary complications still remain as problems that require attention and study for their prevention and treatment. It seems unlikely that any single technical or therapeutic advance will eliminate their occurrence or entirely simplify their treatment. However, with an understanding of their etiology, and with careful attention to certain details before, during, and after operation, the incidence of pulmonary complications may be reduced materially, and their treatment made rational and effective.

PULMONARY EMBOLISM

Pulmonary embolism will not be discussed at length. Cutler² believes that embolism is the chief etiological factor in postoperative pulmonary affections, and that pneumonia, abscess, pleurisy, and empyema arise from emboli smaller than those causing major fatal pulmonary embolism. He emphasizes the importance of careful surgical technic in avoiding trauma and infection in the prevention of embolism.

In this connection it is perhaps fair to state that the greatest number of postoperative pulmonary emboli arise from wounds in which inflammation, if not infection, has occurred. Three recent experiences with major fatal pulmonary embolism have followed, first, an operation for the removal of a large calculus from the urinary bladder; second, an operation for the drainage of an extensive perirectal abscess; and third, an operation for the application of

radium for carcinoma of the uterine body. In all three instances inflammation was certainly present at the time of operation, and in at least two, infection also.

Thrombophlebitis of the leg veins is a source of pulmonary emboli. Adequate postoperative exercise should be used in efforts to prevent thrombophlebitis of the saphenous, and femoral veins.

ATELECTASIS

Atelectasis is the most important of all pulmonary affections following surgical operations, and represents the great number of all cases of so-called *postoperative pneumonia*, which, when present, has usually been preceded and caused by atelectasis. While pulmonary abscess may arise from infarction, the greatest number of cases follows atelectasis. The importance of dental infection in the etiology of pulmonary abscess has been pointed out by Touroff and Moolten.⁸ Postoperative pulmonary atelectasis is caused by the blocking of large or small bronchi by normal or abnormal bronchial secretions. The usual type of atelectasis is lobular; and many segments of pulmonary tissue may be involved bilaterally. But atelectasis may be lobar in type, or involve an entire lung.

Foreign material may be aspirated into the bronchi, and secretions may arise in the bronchi and lungs. Aspirated materials are:

1. Saliva normally present in the mouth;
2. Infected matter from the tonsils and gums.
3. Blood clots following operations in the mouth and nasal passages; and
4. Vomitus.

These materials may be aspirated during and after surgical operations.

Secretions arising in the bronchi are:

1. Those normally present;
2. Those due to acute or chronic bronchial pulmonary disease; and
3. Those resulting from irritation of anaesthetic agents, such as ethyl ether. It must be made clear, however, that atelectasis occurs following all types of anaesthesia, and that today the term "ether pneumonia" is properly falling out of use.

THE BENEFICIAL COUGH

Retention of bronchial secretions, which are normally removed by coughing, is necessary for the occurrence of postoperative pulmonary atelectasis. The cough reflex is diminished or absent during unconsciousness resulting from disease, prolonged anaesthesia after avertin, or following large doses of morphine.

Debilitating diseases and surgical conditions requiring extensive operations may diminish the strength of patients sufficiently to interfere with effective coughing. Major upper abdominal operations with their often painful wounds are known to be frequently complicated by postoperative pulmonary atelectasis.

Semb⁷ noted the occurrence of atelectasis following the use of transnasal tube drainage of the stomach after gastric operations, and points out that nasal tubes are a factor predisposing to atelectasis by interfering with elimination of bronchial secretions. One may appreciate the difficulty of a patient in developing an effective cough, as he lies in bed with a painful wound, a gastric tube passing through the nose and pharynx, and an intravenous needle in an ante cubital vein.

Paradoxical movement of the thoracic wall following operations on the lungs and pleura also diminishes the effectiveness of coughing. Furthermore, the task of the cough is increased by the thick tenacious sputum often associated with pulmonary atelectasis.

Efforts to prevent postoperative pulmonary complications should begin prior to operation by avoiding surgical procedures not imperative in the face of acute respiratory infections, and by the care of the teeth to eliminate the large

amounts of infected material present on the gums of many patients. Should large quantities of sputum be present resulting from chronic disease such as bronchiectasis, they should be eliminated through coughing, postural drainage, or bronchoscopy immediately prior to operation.

During and after operation the Trendelenberg position should be used whenever possible, since it permits bronchial secretions to pass by gravity to the mouth, rather than in the opposite direction to the bases of the lungs. It is desirable that patients awaken and cough promptly following operation. The medical and nursing staffs should urge and aid the patients to cough at frequent intervals.

Abdominal wounds should be supported by firm binders, and additional support given by hand during coughing. These are great aids in reducing pain, and giving confidence to the patients. Since coughing is often more effective with the patients in the sitting and semi-erect positions, rather than in the supine or Trendelenberg positions, attention should be given to permitting patients to assume the most favorable position whenever coughing is urged and aided.

The employment of both lateral positions has been advocated properly in the prevention and treatment of pulmonary atelectasis. At regular intervals patients should be turned and not allowed to remain for long periods on their backs. Steam inhalations and expectorants are useful in loosening sputum. It is hardly necessary to mention that an adequate fluid intake is necessary to prevent inspissation of bronchial secretions. Inhalations of ten and fifteen per cent carbon dioxide have been recommended for the prevention of pulmonary atelectasis. It should be emphasized, however, that carbon dioxide inhalations must be followed by voluntary cough and expectoration since they may be harmful in permitting further gravitation of secretions to the bases of the lungs in patients in the semi-Fowler position. The Trendelenberg position should be used whenever the inhalations are administered to unconscious patients. Previously the dangerous overdosage of narcotics has been mentioned with its attended semi-consciousness and loss of cough reflex,

which lead to retention of bronchial secretions. Sufficient quantities of opium derivatives should be given, however, to control pain, for it may be a great deterrent to effectual coughing. Attendants must be aware of the necessity that patients who have received morphine and similar drugs should be urged to cough.

DIAGNOSIS OF ATELECTASIS

Postoperative pulmonary atelectasis should be diagnosed at an early stage whenever attention is paid to the possibility of its occurrence. The most important early, as well as late, sign is the wet, unproductive cough associated with audible râles that are heard often at some dis-

fremitus. The classical physical signs of displacement of the heart, trachea, and other mediastinal structures toward the affected lung are present whenever its volume is diminished sufficiently. Sharp elevations of the temperature and the pulse and respiratory rates are shown usually by the clinical chart.

Roentgenological examination confirms the diagnosis of pulmonary atelectasis, with the demonstration of decreased aeration of the involved pulmonary segments. The characteristic roentgenological findings are foci of opacity in the lung fields, elevation of the diaphragm, displacement of the heart, trachea, and other mediastinal structures toward the involved

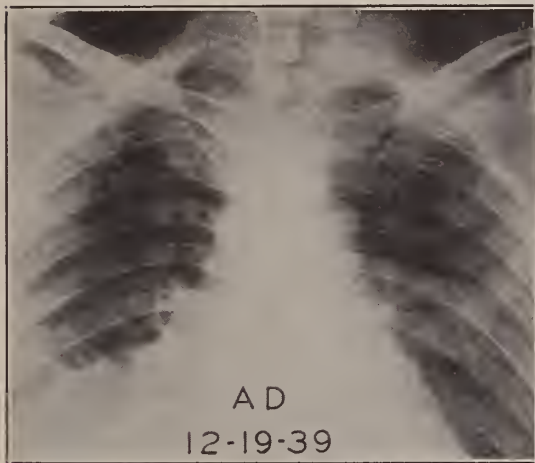


Fig. 1 (Case 1)—Bedside roentgenogram demonstrating extensive atelectasis of the lower right lung with patchy atelectasis of the left lung.

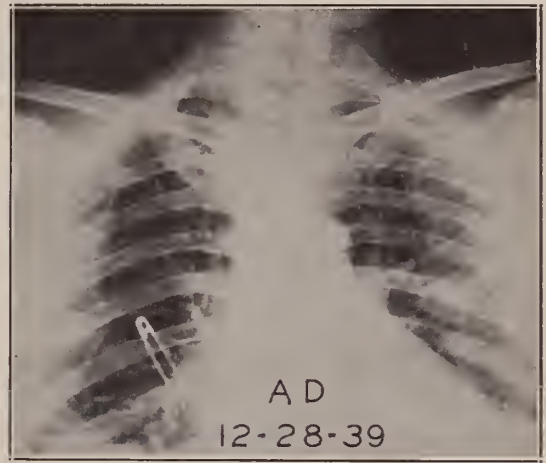


Fig. 2 (Case 1)—Postero-anterior roentgenogram showing clearing of the right lung with some persistent involvement of the left.

tance from the patient. This cough may be the only evidence of an impending atelectasis. The patient is often cyanosed, uncomfortable, and apprehensive. Cyanosis with dyspnea increases with the extension of the disease. Dyspnea may occur, however, with gastric and intestinal distension, which may seriously diminish vital capacity. These conditions may have to be differentiated from atelectasis, or they may be present concurrently and add to the burden on the respiratory system.

Physical examination of the thorax demonstrates shallow respiratory movements, an impaired percussion note over the affected portion of lung, râles with high-pitched or suppressed breath sounds, and usually diminished

lung, and narrowing of the intercostal spaces of the affected hemi thorax. As Brunn and Brill¹ have pointed out, all the typical findings are usually not present in every case. Furthermore, it cannot be stressed too much that the usual picture is that of bilateral lobular atelectasis, which may not roentgenologically be differentiated from bilateral lobular pneumonia. With approximately equal bilateral involvement of the lungs, it is evident that classic cardiac and mediastinal displacement will not occur.

CASE REPORT

Bilateral pulmonary atelectasis: A. D. (Case 1, Figs. 1 and 2), male, aged 49, was operated upon December 16, 1939, for acute cholecystitis and the gall-bladder was removed. December 18, two days later, cough and expectoration were noted; and on

auscultation râles were heard bilaterally posteriorly. The temperature and pulse and respiratory rates were elevated.

A roentgenological examination on December 19 (Fig. 1), made with a portable outfit, showed an extensive atelectasis of the dependent portion of the right lung, and a patchy atelectasis of the lower half of the left lung. The condition of the patient improved with treatment.

A second roentgenological examination, December 28 (Fig. 2), demonstrated clearing of the lesions in the right lung, with some persistence in the left.

The patient made a complete clinical recovery before discharge.

TREATMENT

The successful treatment of postoperative pulmonary atelectasis depends upon the establishment and maintenance of the adequate bronchial drainage that has been absent. The tracheobronchial tree must be kept free of secretions. If the measures already described for the prevention of pulmonary atelectasis have not been used, they should be applied, and frequently they will suffice. Oxygen therapy, preferably with the nasal catheter method of administration, is of great value in cyanosed and dyspneic patients. Blood transfusions are certainly to be used to support those seriously ill.

Atropine should never be given in misguided efforts to "dry up secretions", for their elimination is made more difficult by the attendant inspissation.

The following clinical history illustrates factors favorable to the development of pulmonary atelectasis, the roentgenological features of massive atelectasis, and its successful treatment by simple measures.

CASE REPORT

Massive pulmonary atelectasis: J. M. (Case 2, Figs. 3 to 5), male, aged 55, was admitted October 24, 1939, with a diagnosis of carcinoma of the rectum. Symptoms had been present for nine months. On November 2, after suitable preparation, a first-stage combined abdomino-perineal resection of the rectum according to the Lahey method was performed with spinal anaesthesia.

After the operation, the patient, whose condition was satisfactory, was placed in the Trendelenburg position. The wound dressing had been securely fastened with adhesive, and a firm abdominal binder had been applied.

On the third postoperative day, November 5, the wound was dressed and the occluding clamp removed from the permanent left lateral colostomy opening. That evening the nurse noted frequent

cough and expectoration; the patient spent a restless night and complained of pain in the region of the operative wounds.

The following morning, November 6, the patient was found restless and apprehensive; the lips were cyanosed; an ineffective, non-productive wet cough and audible tracheal râles were present; on auscultation coarse râles were heard posteriorly up to the mid-portions of both lungs.

The patient stated that he was afraid to cough since the effort caused severe pain at the site of the wounds, and a fear of disruption. Examination showed that the firm adhesive strapping had been replaced by loose tapes without an abdominal binder; furthermore, although instructions had been given that the patient should lie on both sides, only the right lateral position had been assumed, since the left had been to uncomfortable for the patient after the dressing of the wounds.

A firm corset-type of adhesive support for the dressing was substituted for the loose tapes, and a tight, many-tailed abdominal binder was applied. A portable roentgenogram (Fig. 3) demonstrated an



Fig. 3 (Case 2)—Bedside roentgenogram demonstrating the classical picture of massive atelectasis of the right lung.

extensive atelectasis of the right lung with displacement of the heart and mediastinal structures to the right, elevation of the right hemi diaphragm, and narrowing of the right intercostal spaces. The patient, who was already coughing effectively and voluntarily with additional support being given the wounds manually, was placed on the left side to facilitate drainage of the right bronchial tree. Large amounts of tenacious purulent sputum were readily raised and expectorated. A transfusion of 625 c.c. of citrated blood was given.

That evening, November 6, a striking improvement in the patient's condition was noticeable. The previously apprehensive man had now regained his confidence, and understood his condition and its therapy. The temperature, and the pulse and respiratory rates, that had begun rising November 5 and had reached 102.4 degrees, 120, and 44, respec-

tively, the morning of November 6, had fallen to 99.6 degrees, 104, and 26 per minute. A portable roentgenogram, November 7 (Fig. 4), showed a marked clearing of the right lung with a slight patchy involvement of the left. The spread to the left lung is explained by the use of the left lateral position in promoting drainage from the seriously involved right lung and bronchial tree.



Fig. 4 (Case 2)—Bedside roentgenogram showing a marked improvement of right lung lesions with slight involvement of the left lung after twenty-four hours of therapy.

The patient's condition continued to improve. He was discharged November 19, and readmitted November 27. A roentgenogram, December 12 (Fig. 5), demonstrated absence of foci of consolidation in



Fig. 5 (Case 2)—Postero-anterior roentgenogram taken prior to second stage excision of rectum showing essentially normal lung fields.

the lungs. The second stage combined abdomino-perineal resection of the rectum was performed successfully December 16. The patient later was discharged in good condition. No pulmonary complication followed the second operation.

The history of the patient J. M. illustrates several mistakes in postoperative care that led to the development of pulmonary atelectasis. Proper support of the painful wounds had been omitted, and ineffective coughing had resulted. With the patient kept on the right side, the bronchial secretions passed by gravity into the right bronchial tree and led to an atelectasis of this entire lung. Striking and rapid improvement followed the application of proper measures of therapy, including blood transfusion.

INTRATRACHEAL AND INTRABRONCHIAL SUCTION

Although the measures already described and illustrated often suffice in the prevention and treatment of postoperative pulmonary atelectasis, they may fail. In this event intratracheal and intrabronchial suction described by Haight³ should be used at once.

Intratracheal suction is carried out with a double-eye No. 16 F rubber catheter, preferably not too soft, which is introduced through the nose and into the pharynx and is advanced through the larynx and into the trachea on inspiration. Voluntary coughing, or coughing stimulated by turning on the electric suction pump to which the catheter is connected, will open the larynx widely and permit the catheter to enter the trachea; stimulated coughing is often necessary with semi-conscious patients.

By choice, a Lukens bronchoscopic collection tube intervenes between the catheter and the suction pump, since the collection tube is useful in measuring the quantity of secretions removed. Suction is applied by occluding with a finger the quarter-inch hole in the rubber stopper which fits the collection tube. Although this tube is convenient, it is not necessary since suction may be interrupted merely by pinching the catheter. Following the introduction of the catheter into the trachea all secretions are aspirated from it before the catheter is moved into the bronchi.

Since the right bronchus arises almost directly from the trachea, the catheter is usually readily advanced into it. Introduction into the left bronchus is facilitated by turning the head and face sharply to the right before moving the catheter forward. The suction should be applied for only a few seconds at a time, so as to allow the patient to breathe quietly between

aspirations. The coughing stimulated by suction brings secretions from the smaller bronchi into the larger, from which they are readily aspirated.

The useful measure of intratracheal and intrabronchial suction is readily carried out throughout hospitals by the use of a portable electric suction pump. It may be used in the operating room during and immediately after operation whenever secretions are noticed in the bronchi and are not otherwise removable. By its use dramatic results in the restoration of patients unconscious from anoxemia are obtained. Usually at least fifteen cubic centimeters of secretions are removed, but much larger amounts may be obtained. Intratracheal and intrabronchial suction may, and should be, carried out repeatedly, if necessary, to keep the tracheobronchial tree free of secretions.

BRONCHOSCOPY

Bronchoscopy in the treatment of pulmonary atelectasis was advocated by Jackson and Lee,⁴ and should be used whenever intratracheal and intrabronchial suction by catheter is impossible or seems to be unsatisfactory. Whenever its use is necessary, no delay should be permitted in resorting to bronchoscopy. The procedure may best be carried out in the patient's room, with the patient seated almost upright supported by the raised back of the bed. The operator stands on the bed behind the patient and introduces the instrument usually with ease. During the operation oxygen may be administered through the distal suction tube present on the standard bronchoscope.

Direct visualization of the trachea and bronchi is afforded, and loose secretions and bronchial plugs are removed by suction. Epinephrine solution may be applied to swollen and inflamed mucous membranes. At times it may be advisable to employ bronchoscopy even when catheter suction has been used, in order to be sure that all secretions have been removed.

Postoperative patients tolerate bronchoscopy well. Lee, Tucker, and Clerf⁵ have shown the striking value of early bronchoscopy in the treatment of postoperative pulmonary atelectasis.

PULMONARY ABSCESS

Pulmonary abscess occurring postoperatively usually follows atelectasis, although it may occur secondary to pulmonary embolism especially the septic type; in embolic cases the abscesses are frequently multiple. The importance of dental infection in the etiology of lung abscess has already been mentioned, and proper care of the teeth prior to operation should reduce the incidence of postoperative pulmonary abscess. The treatment of pulmonary abscess cannot be discussed here in detail. Non-surgical methods should not be persisted in for long periods before open drainage is resorted to. Neuhof and Touroff⁶ have shown excellent results of early drainage of acute pulmonary abscess.

CASE REPORT

Postoperative Pulmonary Abscess: P. Y. (Case 3, Figs. 6 to 8), male, aged 36, was admitted September 24, 1939. At the time of examination, and throughout his hospital stay, the dental hygiene was excellent.

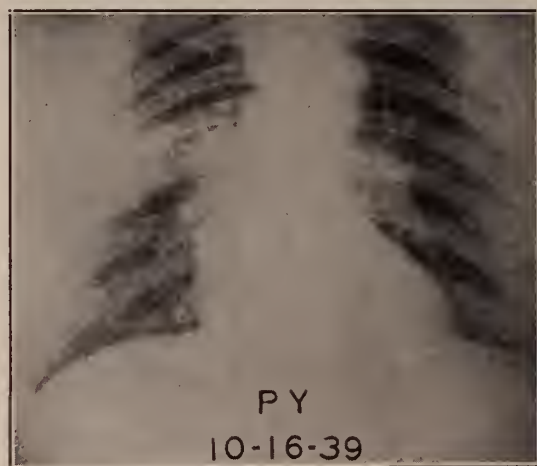


Fig. 6 (Case 3)—Postero-anterior roentgenogram demonstrating patch of pneumonia in mid-right lung field.

September 25 a hemorrhoidectomy was performed with nitrous oxide, oxygen, and ether anaesthesia. During the operation considerable difficulty was experienced with the anaesthesia, and hemoptysis occurred following the introduction of a metal airway.

After the patient returned to his room, cyanosis was present. Carbon dioxide inhalations were administered; and because of the excessive amount of thick sputum present, one one-hundredth grain of atropine sulphate was given hypodermically. The following day, September 26, hemoptysis occurred;

and on September 27 a chill. The sputum remained tenacious for some days without further hemoptysis. The temperature and pulse and respiratory rates were elevated.

When the patient was seen in consultation October 16, twenty-one days following operation, cough and expectoration of thin, non-foul-smelling sputum were present. A roentgenogram (Fig. 6) dem-

At a bronchoscopic examination on October 26, pus was seen coming from the orifice of the right upper lobe bronchus, whose mucous membrane was reddened and thickened. A roentgenogram October 30 (Fig. 7) showed that a cavity had developed, which, in stereoscopic films, was seen to lie in the lower portion of the upper lobe, and to point on the accessory interlobar fissure.

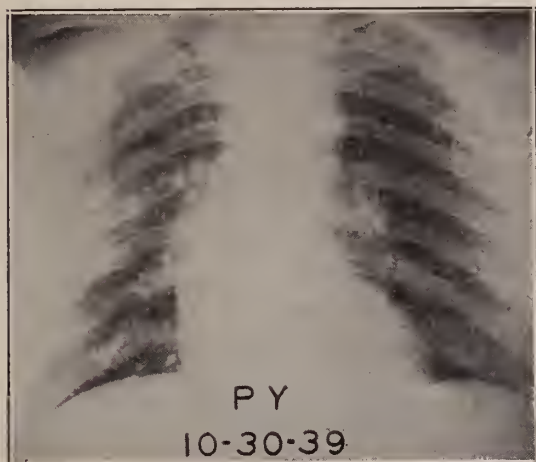


Fig. 7 (Case 3)—Postero-anterior roentgenogram demonstrating excavation occurring in right lung after treatment with bronchoscopy and postural drainage.

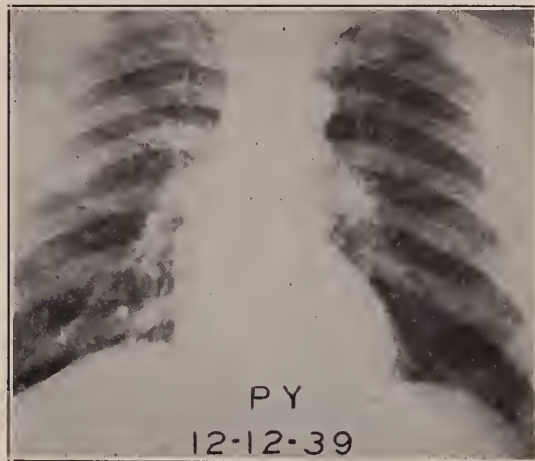


Fig. 8 (Case 3)—Postero-anterior roentgenogram showing complete resolution of abscess of right lung.

onstrated a focus of infiltration in the right mid-lung field. A diagnosis of pulmonary abscess was made. Postural drainage improved the condition of the patient.

The condition of the patient continued to improve, and serial roentgenograms showed resolution of the lesion. The final film, December 12 (Fig. 8), showed disappearance of the abscess, the patient was discharged, and he is now, April 1, 1940, working steadily.

SUMMARY

Pulmonary atelectasis, which is the most important postoperative pulmonary complication, is caused by the blocking of the bronchi with aspirated material, or with secretions originating in the bronchi and lungs.

The prevention and treatment of atelectasis depends upon the elimination of secretions from the bronchi, which may usually be accomplished by attention to certain details of care before, during, and after operation.

Intratracheal and intrabronchial suction as

suggested by Haight, and bronchoscopy, have a very important place in the prevention and treatment of postoperative pulmonary atelectasis.

Pulmonary embolism, another serious postoperative complication, is often associated with inflammation and infection in operative wounds. Care to prevent these occurrences should lessen the incidence of pulmonary embolism.

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THE TREATMENT OF CHRONIC NEPHRITIS IN THE LIGHT OF CONTEMPORARY PHYSIOLOGY

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Read before the Section on Medicine at the Annual Meeting of The Medical Society of New Jersey in Atlantic City, June 5, 1940.

Many years ago Dr. Bright himself made the following statement: "It is a humiliating confession that, although much attention has been directed to this disease for nearly ten years, little or nothing has been done toward devising a method of permanent relief when the disease has been confirmed, and no fixed plan laid down as affording a tolerable certainty of cure in the more recent cases." After all these intervening years we must still honestly confess the existence of the first difficulty, despite the fact that we are a little more secure, so far as the second is concerned.

No claim can possibly be made for either originality of effort or thought. Much, if not all, of this summary probably is thoroughly known and understood by all of you; yet the presentation of an old subject in a new light, and especially to a large group of physicians who are carrying the load of general practice, warrants any effort that may be made to clarify any existing misconceptions, and point the way toward better therapeutic procedures.

The motive that prompts this paper is the hope not only that it may result in useful and valuable discussion, but also that it may serve as a stimulus to those of us who are engaged in the practice of medicine to wage more thoughtful warfare upon one of the needlessly fatal and crippling maladies which confront the human race today. Last, but by no means least, is the hope that the rational treatment of this particular form of chronic nephritis can safely and sanely be reduced to relatively simple terms.

Certain it is that our understanding of the condition which is frequently called synonymously Bright's disease and nephritis has undergone many important changes in recent years. One may simply mention some newer approaches to our knowledge of normal kidney function; numerous chemical studies of the blood and body fluids; a much more compre-

hensive understanding of the pathology and histologic changes of diseased kidneys; better utilization of blood pressure studies and ophthalmoscopic findings. A host of other refinements have brought us to the point where we have definitely drawn away from the old-fashioned use of gross anatomic descriptions and have come to the point of view of considering nephritis, especially the chronic form, *not* as a disease of the kidneys, but rather of the entire organism, and have come to the conception of renal insufficiency more or less analogous to cardiac insufficiency, which serves as a much better therapeutic guide in the handling of this disease.

According to a recent article by Dr. Edward Weiss, under the heading of nephritis may be appropriately included three forms of renal disease: (1) Glomerulo-nephritis, acute or chronic; (2) nephrosis, which presumably is a primary degeneration of the tubular structures of the kidney; and (3) nephrosclerosis, another term for arteriosclerotic or vascular disease of the kidney, resulting most frequently from cases of a so-called essential hypertension. Of these three, the first-mentioned can more appropriately be called nephritis, rather than the other two. In this connection, it probably would be wise for all of us if we remembered the rather classical definition of nephritis which was given by Christian years ago, which reads, "Nephritis may be defined as a diffuse, progressive, degenerative, or proliferative lesion, involving the renal parenchyma, the interstitial tissue, or the renal vascular system, or all three simultaneously."

THE STRUCTURE OF THE KIDNEY AND ITS PHYSIOLOGY

The statement was made by Marshall Hall, "To become good and enlightened practitioners, we must become able physiologists." It follows, therefore, that a reasonable knowledge of the structural make-up of normal kidneys, and of

what normal kidneys can be expected to do, would be a prerequisite to the intelligent understanding of how they function in various diseases.

The structural unit of the kidney, in the light of modern physiology, is spoken of as a *nephron*. By this is meant a *glomerulus*, surrounded by *Bowman's capsule*, which in turn marks the beginning of a *resorptive tubule*, terminating in the *collecting tubules* which ultimately discharge urine into the pelvis of the kidney, and thence to the outside world.

Each nephron is supplied with an afferent artery, which discharges into efferent vessels, and finally into an immense capillary net-work which surrounds both the glomeruli and the tubules.

It is roughly estimated that there are between one and a half and two and a half million nephrons in each kidney, and that the aggregate of all of these minute nephrons is the equivalent of a huge filtration plant, which has a surface magnitude at least equal to that of the skin.

Throughout this huge filtration plant an enormous amount of blood passes per unit of time, regulated in some mysterious way, by nervous influences; and it is roughly estimated that in health at least one thousand to fifteen hundred liters of blood per day go through the renal filtration bed. As a result of this filtration process, a fluid is secreted, in which there are so-called non-threshold bodies that are no longer of any value to the human machine, and hence are eliminated. These are chiefly the end products of protein metabolism. Other so-called threshold substances, which are essential for the body's efficient economy, undergo a certain amount of resorption in their passage through the tubules, and are retained in amounts regulated by bodily needs. These consist chiefly of water, salt, sugar, and bases. By these processes of filtration and resorption, using the words of Claude Barnard, the body not only attempts, but actually succeeds in maintaining a *constant internal milieu*, in contrast to an *ever-changing external* one. Though the process of urinary secretion is not as simple as this summary may sound, it is believed that for all practical purposes these are the salient facts to be remembered.

THE FUNCTIONS OF THE KIDNEY

The functions of the kidney are three-fold: (1) The maintenance of water and plasma balance; (2) the elimination of waste products of protein metabolism; and (3) they aid in the maintenance of a normal acid-base equilibrium.

Of these functions, the regulation of water balance is by all odds the most sensitive and delicate one, and is the first to falter in disease. It may be said that normal kidney functioning involves the ability to excrete a large excess of fluid, in a minimum of time; the ability to concentrate the urine to a maximum degree and at the same time to eliminate all of the products of protein metabolism under all conditions of protein intake. This involves the concept that by no means are all of the nephrons always working. There probably are periods of complete rest for many, or there are automatically nervously regulated shifts, so that some work while others repose; similarly, there must be some mechanism whereby the entire filtration plant goes into action when occasions demand; and, conversely, many of the filtration units shut down completely during such a period of time when water needs to be conserved as a result of some pre-renal deviation of the fluid contents of the body. Yet in the resultant small volume of urine excreted all of the waste products, or non-threshold bodies, are concentrated, but at the same time the requisite amount of threshold substances are retained.

It is upon this conception of renal function that the modern tests of the concentration and dilution types are based; and it should be pointed out here that this function, being the most delicate one, is the first one to suffer in chronic nephritis, and it is the first to show impairment, long before other tests of renal insufficiency become positive. It might also be pointed out that it is not until at least half or three-quarters of the nephrons are destroyed by the disease process, that the function of the elimination of the waste products of protein becomes materially impaired to the point where there is actual blood retention and uremia threatens.

It might be apropos to mention, on the basis of these facts, that far too little discrimination is employed in the utilization of blood chemistry studies in our daily work. Thousands of

needless and thoughtless non-protein nitrogens and urea nitrogens, and other blood chemical studies, are asked for, particularly in the hospital, that could be very significantly cut down with a resultant saving of a tremendous amount of both money and effort; for it is not until the concentration capacity of the kidneys has become materially lowered and the compensatory phenomenon of polyuria has become marked, that one is apt to encounter abnormalities in the nitrogen content of the blood. This has no small significance in terms of what one might call *medical economics*, and the amount of wasted time and money that these procedures are now producing is worthy of thoughtful consideration on the part of all practitioners.

Though much could be said and written about the value and interpretation of the various tests of renal function as they are applied to the blood and urine, and combined studies of these two, the opinion is held that "the most accurate and complete information regarding the functional ability of the kidneys is obtained by the *concentration ability*; and after that, by the so-called *urea clearance* test." The first of these at least can be intelligently and efficiently applied by general practitioners without recourse to complicated laboratory procedures. The author is in entire accord with Freyberg in this particular matter.

It must at once be apparent that, between normally functioning kidneys on the one hand and complete renal insufficiency on the other, with impending uremia, there is an extremely wide field. In this we encounter all degrees of prolongation of water excretion above the minimum requirements, and all grades of impairment on the part of the kidneys to concentrate urine; we encounter clinically varying degrees of chronic nephritis which have to be treated and interpreted in the light of relative insufficiencies of varying degree, short of total inadequacy. The length of time required for damaged kidneys to progress to the point where they are no longer able to carry on and eliminate all of the waste products is an extremely variable one, and usually a slow, time-consuming process. It is probable that until the kidneys are no longer able to concentrate a urine of a

specific gravity of more than 1010, the end stages of complete renal insufficiency have not been reached.

This conception of chronic nephritis carries one over periods in which the process may be entirely latent or symptomless, and discovered only by accident, through varying periods of relative, but obvious renal impairment of a non-serious degree for the time-being, and brings us ultimately to the period of complete renal insufficiency with uremia, provided no other organs give out beforehand. This conception aids one in understanding why treatment, in its various forms, has to be on a long-range basis; at no stage can it be dogmatic; various complications which may arise alter the complexity of therapeutic attack. When all is said and done, the changes which are made in any therapeutic program should be based upon common-sense reasoning, a knowledge of where the patient rates in terms of renal functioning, and the development of special conditions which demand special forms of therapeutic attack. Consequently, we should no longer think of the treatment of chronic nephritis as though it were more or less a cut-and-dried thing. The conception should be that the therapy of chronic nephritis must be chronic, *comprehensive therapy*, directed over a broad range of both time and vision, and applied also, unfortunately, with the knowledge that ultimately there is no staving off of the fatal end.

TREATMENT

In the light of the foregoing remarks it must be apparent that the treatment of chronic nephritis is a variable one, modified chiefly by complicating factors, such as oedema, anaemia, hypertension, cardiac failure, and others which, fortunately, are more common to the later stages of the disease than they are to the earlier period. We have to admit that "we can neither attack the underlying etiological causes, nor treat the pathological process in any fundamental way". We attempt to maintain the proper physiological balance of the body; and in so doing, not only enhance the comfort of the patient but in some cases at least ameliorate the course of the disease. Treatment needs to be directed not only along common-sense lines,

but humanitarian ones as well. The old adage of Von Noorden, "Forbid as little, instead of as much as possible," is far too little heeded, and needs reëmphasis along certain lines. Treatment can be appropriately broken down into a few major details, and of necessity these must be dealt with briefly:

1. *Diet*: It is difficult and impossible to make any comprehensive statement as to the dietary needs of the nephritic, for there are so many modifying factors which depend upon the stage in which one encounters the disease. Briefly, one can say that the dietetic program for these patients should be, 1, to spare the damaged kidneys as much as possible; 2, to permit of any possible structural recuperation; 3, to prevent oedema and the supervention, as long as possible, of uremia; and 4,—last, but by no means least,—to maintain nutrition at as high and efficient a level as possible, remembering that chronic nephritis, particularly in its later stages, is a wasting disease, bringing with it a group of symptoms which have to be dealt with appropriately.

Protein: One of the main points which needs emphasis refers to the *protein* content of the diet in chronic nephritis, and it is believed that many doctors and patients as well are influenced too much by traditional, hand-me-down theories, rather than by established facts. There is no evidence of which the author is aware to warrant the belief that a reasonably high protein diet produces the disease in question; or that a reasonable amount of protein in the diet unduly accelerates the course of the disease; or, finally, that there is any difference between the protein of red meats and dark meats, or animal proteins in general.

Conversely, there is abundant evidence to show that too drastic protein restriction not only does harm in certain ways, but, beyond a certain point, it cannot be enforced, for the body will metabolize its own store of proteins to make up for any dietary deficit. The dietary requirements for a patient with chronic nephritis without oedema are that the protein content is essentially normal or, at most, moderately restricted; the carbohydrate content is high; and the caloric intake adequate to maintain nutrition.

Until about twenty-five years ago it was held that by curtailment in protein intake the kidneys were being spared and protected,—which is good in theory, but not true in fact. It has been clearly shown that an inadequate protein-containing diet carries with it definite risks, in the sense that it favors malnutrition, the development of anaemia, and apparently increased susceptibility to infection. Moreover, an inadequate protein diet may actually promote tissue degeneration or impoverishment not only in the kidneys themselves, but the body generally. Because of these facts and others too numerous to mention, modern dietetic therapy includes a *reasonably high* protein content; and any significant curtailment is not clearly indicated until the stage of renal insufficiency is reached, at which time, incidentally, dietary measures and all others are apt to fail. To some these statements may seem heretical, and yet they are the dominating thoughts in the minds of so-called master clinicians in the field of nephritis today.

It should also be emphasized that the factor of abnormal dietetic restriction has a bad, potent, *psychological* influence upon many patients, since they are reminded every time they sit down to eat that some sort of a sword of Damocles is hanging over their heads, which may fall sooner than necessary if they deviate from the dietetic rules that have been laid down. Patients with entirely too many and too empirical dietetic "Dont's" hung around their necks are harmed more often than they are helped. This factor is responsible in some instances, I believe, for needlessly high elevation of blood pressure, which may be traced back to the effect of dietetic and other forms of therapeutic "Dont's".

Briefly, it would seem as though one could summarize the dietetic principles involved in the treatment of this disease, as follows: At no time, even up to the end stage in which renal insufficiency is on the horizon, is there any rational justification for such protein curtailment in either quantity or type as has been, and still is, the tendency for many physicians to invoke. Patients with this form of nephritis need, among other things, to be kept comfort-

ably happy, and this can certainly be achieved in part by the exercise of dietetic sanity.

2. *Salt*: A word should be said with reference to the much-discussed problem of salt restriction. It is perfectly true that in certain types of chronic nephritis associated with the nephrotic rather than the cardiac oedema, marked salt restriction is necessary. On the other hand, in the type of nephritis under discussion, there is little favorable that can be said for the fetish which puts people upon a markedly restricted intake of salt, and hence a thoroughly unpalatable diet. Normally, the daily intake of salt, more or less automatically regulated by instinct, is between four and five grams. The present vogue of cooking without the addition of any salt—salt-free butter, salt-free bread, salt-poor foods—not only makes for unnecessary unpalatability of the patient's diet, but still further hampers appetite, and augments psychic trauma and strain.

It has been shown quite clearly that it is the sodium ion that is responsible for the retention of water; whereas, the chloride is actually a definite diuretic. It follows, therefore, that most of the salt substitutes that have been introduced, which are sodium salts of various acids, probably have no virtue. The substitution of potassium salts, particularly the chlorides, is somewhat more rational, particularly since these salts are well tolerated by most patients, especially when given in capsule form; but this does not meet the problem at all satisfactorily, for capsules do not impart taste to food, and potassium chloride per se is not a palatable substitute for table salt. It would seem that except under extreme circumstances, in which oedema is a pressing problem, there is no rationale for going any further than asking the patient to add little or no free salt to his diet, other than that which is added to it in the kitchen.

3. *Fluids*: In this form of chronic nephritis one must always remember that more filtration units are constantly at work in an effort to provide a compensatory polyuria in which the waste products of protein metabolism are carried off; therefore, it is necessary to provide an adequate amount of fluid which, in the compensated form of chronic nephritis, will aver-

age perhaps two or even three liters per day.

A clinical guide for the amount of fluid to be consumed can be found in intelligent determinations of the *specific gravity* of the urine secreted. As long as gravity readings of 1015 or higher are the rule, probably one and a half to two liters of total fluids per day will supply an adequate elimination medium. As the specific gravity tends to become more and more fixed at a *lower* level, the kidneys automatically demand a greater supply of fluid to carry on their eliminative functions; therefore, the amount of fluid, regardless of the type, has again to be determined on the basis of the individual patient, plus any complicating factors, such as oedema, cardiac insufficiency, and pronounced hypertension.

One other important point should be mentioned in this respect, and that is that the amount of fluid ingested should be really available for kidney functioning; and when for any reason there is any pre-renal deviation of fluids, modifications may be necessary, involving, among other things, appropriate measures to cut down, or cut out, the cause of any pre-renal deprivation of fluids.

There is no reason why the fluid content should not include reasonable amounts of tea or coffee; and it is at least questionable whether the moderate use of the milder alcoholic beverages, according to the habits and custom of the individual, does any particular harm. Certainly, on the assumption that too many "Dont's" are harmful rather than helpful, it is a matter of debate whether the occasional preprandial cocktail, or a single highball of an evening, or a glass of light wine with the evening meal, or a bottle of beer, in any way adversely modifies the course of this malady. "If these amenities of life seem to mean much either to the enjoyment or well-being of the individual, it is doubtful whether their curtailment is necessary."

4. *Anaemia*: In the latent and compensated forms of chronic nephritis, anaemia may not make its appearance, and particularly so if adequate dietary measures which have been discussed are maintained. Almost inevitably in the later stages, in which renal insufficiency becomes more and more prominent, or earlier

in the case of patients who are kept upon a needlessly low-protein, low-salt regime, anaemia intrudes. When one reaches the stage in which the eliminative function is materially involved, anaemia is merely the bone marrow evidence of a generalized break-down in the whole body economy; and when this stage is reached, practically no measures will avail in terms of permanency and completeness of the cure of the anaemia. Therefore, one can more or less categorically state that anaemia in the earlier and compensated stages of chronic nephritis can usually be prevented by the ordinary measures of an anti-anaemic nature, plus the utilization of such dietetic knowledge as will safeguard the patient in this respect.

In the late stages of renal impairment, anaemia becomes a serious problem, and probably the only measures which will be of any avail temporarily are repeated *transfusions*. It should be clearly understood, both by the doctor and the patient's family that, though transfusions may relieve the anaemia and probably do not influence blood pressure adversely, they exercise nothing in the way of cure of the fundamental and underlying process as it concerns the kidneys.

5. *Drugs*: There is little, if any, use for the administration of drugs in any form in the reasonably well-compensated stage of chronic nephritis. Drug therapy really is limited to those complications underlying the nephritic condition, which may manifest themselves transiently or persistently as the process advances. These can be summarized under the headings of oedema, myocardial failure, the many symptoms referable to the usually existing hypertension, and anaemia which has already been discussed. About each of these phases much could be written. One thing is important to bear in mind, and that is that diuretics are at no time indicated, at least in the absence of the complicating factor of oedema.

Where the oedema is nephritic or nephrotic in origin, diuresis is usually obtained by the use of a high-protein diet, plus the utilization of some of the mercurial medications; and these, incidentally, can be apparently administered almost without danger of causing any

damage or exacerbation of the underlying renal condition. Best given intravenously, extreme care should be exercised that none of the medication escapes into the subcutaneous tissue. Mercurial suppositories are too often irritating, in the author's experience, to warrant their routine use.

Where the oedema is of obvious cardiac origin, the measures usually employed to improve cardiac tonicity, etc., are, of course, clearly indicated; and it is thought that all of the drugs of the so-called xanthine group have not shown themselves to have much, if any, profitable value; at least they do no harm.

If in an uncomplicated, non-oedematous patient, diuresis seems to need stimulation, probably the three most potent and physiologically sound ones are water, carbohydrate-rich drinks, and glucose. These categorical statements are subject to debate, it is clearly admitted; but the consensus of opinion seems to be that there is no more sense in trying to promote diuresis by drugs, where there is an adequate compensatory polyuria, than there is to employ diuretics in the temporary anuric state of acute nephritis.

Symptomatic: It is not forgotten for one moment that many patients will need symptomatic treatment for many of the complaints which are apt to arise during the life history of the chronic nephritic. Such symptoms as headache, digestive disturbances, pruritus, nervous manifestations of all sorts, and a host of others have to be dealt with by appropriate measures; and as time and the process go on, they are apt to become more demanding and persistent. Ultimately when by suitable measures it can be shown that the degree of kidney impairment has reached advanced insufficiency, everything within one's power should be utilized to ameliorate and soften the closing chapter.

To reiterate, there is very little in the form of drug therapy required in the stages of compensated renal impairment. Perhaps the only exceptions to that statement would be: (1) The use of appropriate measures to promote adequate daily intestinal elimination, if necessary; (2) simple measures designed to lessen the general nervous irritability or tension of the

individual, including measures harmlessly helpful for the control of insomnia; and (3) there is much to recommend the belief that chronic digitalis therapy does good in more ways than one.

6. *Prevention:* No article dealing with the treatment of chronic nephritis would be complete if some mention were not made of those things which might have a beneficial effect in a preventive sense. It seems to be a well-established fact that chronic nephritis has at least several modes of origin. It can begin as a sequel of an acute haemorrhagic glomerulonephritis, which is seen more commonly in children and young adults; and though the incidence of total recovery from this illness is fairly high, a certain number of acute forms can be traced directly into the chronic form of renal impairment. It seems certain, also, that in the acute forms of nephritis, streptococcal infections, of the upper respiratory tract especially, less occasionally respiratory infections involving the lungs, are the chief etiological factors. It further seems probable that it is more the effect of the toxins of the streptococci upon the kidneys than true bacterial invasion—call it streptococcal toxin allergy if you will—that is responsible for the renal upsets. It, therefore, follows that any and all measures appropriately instituted to lessen the vulnerability to and the frequency of streptococcal infections clearly are in line with preventive medicine.

The removal of tonsils and adenoids, proper care of the oral cavity and teeth, the clearing up of acute and chronic sinus infections, the prevention of scarlet fever and the common cold—is a large and pregnant chapter, not only in the etiology but in the prevention of chronic nephritis.

A second group develops upon an entirely unknown basis; it is discovered accidentally, and the most painstaking history fails to reveal any antecedent illness which could presumably have been the starting point of the malady. Probably a great many of them do start as a mild sub-clinical form of acute nephritis, manifested only by slight hematuria or albuminuria, both of which may be extremely transient. Whenever these conditions are

found, they should be regarded as potential cases of chronic nephritis, and stringent measures adopted to prevent such an outcome.

It is too early to state with any degree of certainty to what extent chemotherapeutic measures, so much in the limelight at present, can be or should be utilized in the treatment of these precursors of chronic nephritis. Certainly until more evidence warrants it, sulphanilamide and allied drugs should be used with the utmost care, since not only do they appear to exercise a lethal influence upon streptococci in general, but they are also capable of producing renal damage themselves. Special caution must be exercised in their employment where renal damage already exists. This is an unfinished chapter in therapeutics, and at present warrants the practice of cautious conservatism.

Within recent times it has clearly been shown that *pyelitis* and its resultant pyelo-nephritis is another potent source of chronic nephritis. We are challenged to regard with vastly more concern those attacks of acute pyelitis which occur so frequently in childhood, pregnancy, and idiopathically. We are all too apt to regard the presence of small or moderate amounts of pus in the urine as a temporary indisposition; and, once either symptoms or abnormal urinary findings have disappeared, to dismiss the matter from our minds. The probabilities are that, if patients who have suffered from any form of pyelitis were followed much more industriously, we might prevent the ultimate development of many cases of chronic nephritis. In the maintenance of appropriate therapy, no matter whether one employs ketogenic diets, mandelic acid in its various forms, or some of the sulphanilamide preparations, vigilance should not be relaxed until not only is a sterile urine secured, but sterility of urinary output is maintained over a protracted period of time.

It would be a safe thing to postulate that any urinary tract infection, obstructive or otherwise, is possibly the starting point of chronic nephritis; if such a viewpoint is adhered to in our daily practice, probably many cases of nephritis can be prevented.

Last, there remains that group of *chronic nephritis* which results from long-continued,

essential, benign, or malignant hypertension, leading eventually to nephrosclerosis. Unfortunately, the chapters are not yet written which give adequate insight into the prevention of this notoriously common disease.

CONCLUSION

The attempt has been made to point out *some* of the more fundamental basic principles underlying the therapy of chronic nephritis. Many phases of the subject, dealing with the more general hygiene of living, with which these patients should have careful and persistent regulation, have been unavoidably and purposely omitted.

In the light of modern conceptions of renal physiology, our understanding of the problems of renal pathology and of the varying degrees of renal insufficiency, have been clarified, and the problem of therapy has become more comprehensible and probably more satisfactory.

We have to admit, whether we like it or not, that our knowledge about this is still far from satisfactory. We can clearly recognize the disease in its varying shades of clinical advance; we possess ways and tests by which we can measure its progression; we know much more about its pathological physiology; we understand more of the probable causes which produce the illness; but actually we are not much further along the problem of cure, once the disease has gotten a firm foothold, than we were years ago. Much can be done by intelligent means to make the patient more comfortable and the disease less rapidly progressive. We can confidently expect further advances in this chapter of preventive medicine, particularly if we maintain the attitude expressed by Sir William Gull, when he said, "We have no system to satisfy, no dogmatic opinions to enforce; we have no ignorance to cloak, for we humbly confess it."

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GASTRO-INTESTINAL DISTURBANCES IN ENDOCRINOLOGICAL DISORDERS

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Most of the organic, functional, and psychic disturbances of the human body tend to alter the normal physiology of the digestive system. Emotional disturbances, pathological processes in the central nervous system, and shock affect the gastro-intestinal tracts through the sympathetic and para-sympathetic nervous systems.

The historic work of Pavlov on conditioned reflexes of dogs has opened a new era of investigation along these lines. It was my privilege

to visit the Pavlov Institute in Leningrad in 1934, and witness a demonstration of these experiments. Adjoining the Pavlov Institute is the Institute for Medical Research of Leningrad. During my visit there I watched the experimental production of massive hemorrhages in the gastro-intestinal mucosa of cats by means of mechanical and electrical trauma in the region of the pituitary and mid-brain. Professor Pavlov's work and the investiga-

tions above mentioned have given an impetus to extensive researches in scientific centers all over the world.

The correlation between digestive disorders and endocrine disturbances was first observed in connection with Addison's disease. The symptoms of nausea, vomiting, anorexia, diarrhea, the coated tongue, and the sensations of epigastric fullness, pressure and pain, were noted by Addison as part of the syndrome.

Recent researches pertaining to the correlation between the adrenal cortex and the intestinal mucosa point to the important rôle played by the adrenal cortical hormones in maintaining the functional integrity of the intestinal mucosa. According to Verzar,¹ the absorption of fat, glucose, and provitamin B is impaired or entirely destroyed in adrenalectomized animals (cats). This leads to disruption in osmosis and electrolyte and water balance, and results in gastro-intestinal disturbances in the animals. The administration of adrenal cortical hormones restores this balance and causes the disappearance of the gastro-intestinal symptoms.

Addison's disease has been treated successfully with adrenal cortical hormones for some time. In order to maintain life and well-being of these patients, large doses of adrenal cortical hormones were necessary. The chief drawbacks of such therapy is the difficulty in obtaining these hormones in a pure state, the rapid deterioration of the hormones thus obtained, and the expense involved in the elaborate process of extraction. However, the adrenal cortical hormone is now available synthetically as desoxycorticosterone, and is being used by means of intramuscular injection and pellet implantation, according to the technic of Thorn and his associates.^{2,3}

We have used desoxycorticosterone intramuscularly* in 18 patients presenting symptoms of hypo-adrenia, such as: anorexia, flatulence, hypotension, and visceroptosis; 16 out of these 18 patients responded by a rise in the blood pressure, increased appetite, and improvement in the general well-being; and no

untoward symptoms have been observed in any of these patients. The usual dose is five mg. of desoxycorticosterone intramuscularly, three times a week.*

Celiac diseases of childhood, and "non-tropical sprue" of adults, have been traced to deficient function of the adrenal cortex. Outside of its effect on the intestinal mucosa, the adrenal cortex, as well as the medulla, plays an important part in regulating the carbohydrate metabolism. In this phase of its activity, the adrenal glands function in close coördination with the pituitary and thyroid glands, the pancreas and the liver, as demonstrated by Russell,⁴ Long⁵ and others.

THE ROLE OF THE THYROID AND PARATHYROID GLANDS

The vegetative nervous system, which maintains the muscular tone and peristalsis of the gastro-intestinal tract is affected by the disturbances of the thyroid gland, chiefly by thyrotoxicosis. Many patients suffering from thyrotoxicosis are subject to diarrhea, vomiting, abdominal pains, and anorexia; in others the increased metabolism tends to produce abnormal hunger. The consumption of large amounts of food, particularly carbohydrates, tends to make excessive demands on the pancreas, leading to its exhaustion and often to diabetes.

Hypothyroidism, on the other hand, is associated with intestinal sluggishness, constipation, impaired absorption, and prolapse of the rectum. These symptoms are particularly prominent in childhood myxedema.

The parathyroid glands are chiefly concerned with *calcium metabolism*. In hypoparathyroidism there is a low calcium level in the blood and tissues. The nerve cells and ganglia react to the low calcium content by excessive irritability, manifested by tetany, carpopedal spasm, intestinal spasm (such as infant colic), and convulsions. Spastic constipation, anorexia, and excessive thirst are frequently present. The low calcium level is not always due to

* I wish to thank Dr. Max Gilbert of the Schering Corporation for generously supplying us with the desoxycorticosterone (Cortate), and estradiol benzoate (Progynon B) used in the treatment in our patients.

* Since the paper was submitted for publication fifteen additional cases have been treated with desoxycorticosterone, making a total of thirty-three patients. Favorable results were achieved in twenty-five cases, no effect was noted in seven patients, five of which were psychoneurotic. An unfavorable reaction was noted in one patient only.

deficient parathyroid function. Low calcium diet or impaired absorption of calcium from the intestinal tract will produce the symptom-complex of calcium deficiency. Tetany often occurs during menstruation, pregnancy and lactation, because of the hormonal and metabolic disturbances which occur in these states. In pregnancy excessive activity of the parathyroid in the mother often results in hypoparathyroidism in the foetus, with consequent tetany in the new-born.

The treatment of hypoparathyroidism consists of the administration of parathormone, calcium, and vitamin D. The parathormone lowers the serum phosphorus, and the vitamin D facilitates the absorption of calcium from the intestinal tract (Albright⁶).

A substance known as AT 10 (anti-tetanic preparation No. 10) has been obtained by breaking up vitamin D, and from irradiated ergosterol. It is dihydrotachysterol, and is more efficient and less toxic than vitamin D. It is administered orally, and was first used by Holtz, in Germany in 1933,⁷ then by Arnold and Blum in this country in 1936,⁸ and is now used extensively by Swinton in the Lahey Clinic⁹ and others^{10,11} in cases where the parathyroids have been removed during a thyroidectomy.

Hyperparathyroidism, which occurs in connection with a tumor of the parathyroid or parathyroid hyperplasia, often causes nausea, vomiting, and anorexia.

THE PITUITARY GLAND

The rôle that the anterior pituitary gland may play in causing digestive disturbances is not clear. Anorexia nervosa is often confused with pituitary cachexia, although the former, as its name implies, is of a nervous and psychic origin. Glucose tolerance and insulin tolerance tests can help in the differential diagnosis.

The extracts from the posterior pituitary gland and pars intermedia, however, are efficacious in idiopathic atony of the stomach, and in post-operative intestinal paresis.

The inter-relationship between the pituitary gland and other glands of internal secretion is well known; and in the presence of disturbed carbohydrate metabolism it is impossible to determine the exact rôle played by the pan-

creas, liver, pituitary, thyroid or the adrenal glands. Intense research along these lines is now in progress, and this complex inter-relationship is being gradually clarified.

The observation of Hurst and Steward¹² that peptic and duodenal ulcers tend to heal during pregnancy has led Sandweiss and his associates¹³ to administer daily doses of pituitary-like substances (Antuitrin-S) to dogs, in whom experimental peptic ulcer has been previously produced. In most of the dogs these ulcers healed or improved in twenty to sixty days. Prior to these experiments Shershevsky¹⁴ reported favorably on the use of hypophyseal extracts in the treatment of gastric hyperacidity and gastric ulcer.

While the rôle played by the pituitary gland in causing digestive disturbances is not clear, it is well known that nutritional deficiencies have an adverse effect on the glands of internal secretion, particularly on the pituitary gland. Strenuous and improper dieting for obesity has often resulted in secondary amenorrhea; and it is well known that chronic undernourishment in countries at war causes secondary amenorrhea and sterility in a large percentage of women.

THE GONADS

The rôle played by the gonads in causing digestive disturbances is chiefly limited to menstrual disturbances, pregnancy, and menopause. Nausea, vomiting, and lack of appetite often occur in connection with menstruation. Cyclical bleeding from the gastric mucosa often takes place of menstrual bleeding, and is called *vicarious* menstruation. Gastro-intestinal disturbances of pregnancy are well known and they range from mild nausea to pernicious vomiting. The discussion of the etiology and therapy of toxemias of pregnancy is not within the range of this brief presentation. At menopause the patients often complain of indigestion, flatulence, and a coated tongue. Organic lesions of the gastro-intestinal tract are often coincidental with the occurrence of menopausal symptoms. Routine investigations often reveal cholecystitis, cholelithiasis and gastric and duodenal ulcers.

At menopause, in the absence of organic lesions, the chief finding is a lowered gastric

acidity. This finding has been verified on our patients by means of fractional gastric analysis, carried out in the Gastro-Intestinal Clinic coöperating with our Endocrine Clinic.

The effect of estrogenic therapy on gastric acidity is not uniform. Some authors¹⁵ report beneficial effect, others no effect at all.^{16,17} In our experience, the administration of estrogenic hormones improves the general well-being of the patients by improving muscular tone and vitality. Emotional instability and many functional digestive disturbances are usually improved during treatment with estrogens. Symptoms may recur on cessation of therapy, but very often the patient remains permanently adjusted. A group of menopausal patients are now under a study from this angle, in coöperation with Dr. Bernard Kaplan of the Department of Gastro-Enterology.

CONCLUSIONS

We may conclude from the foregoing discussion that disturbances of the glands of internal secretion, notably the thyroid, parathyroid, the adrenals, pancreas, and the gonads, are usually accompanied by digestive disturbances of various types.

It must not be forgotten, however, that the glands of internal secretion themselves are easily damaged by nutritional deficiencies. These deficiencies may be due to either dietary faults, or the improper absorption of foods from the gastro-intestinal tract. Digestive disturbances also occur in the presence of pathological processes in the central nervous system because of the intimate inter-relationship between the central and vegetative nervous systems and the glands of internal secretion.

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DIFFERENTIAL DIAGNOSIS OF FUNDUS LESIONS ASSOCIATED WITH HYPERTENSIVE VASCULAR DISEASES

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From the Department of Ophthalmology of the New York Post-Graduate Medical School and Hospital (Columbia University). Read before the Eye, Ear, Nose and Throat Section of the Annual Meeting of The Medical Society of New Jersey at Atlantic City, June 8, 1939.

Although the association of lesions of the fundus of the eye with hypertensive vascular diseases has been the subject of many papers during the last few years, its clinical significance and the varied interpretations by internists and ophthalmologists warrant further in-

vestigations and reports in order that the correlation may be better understood. This paper is concerned with fundus lesions occurring in "essential" and "malignant" hypertension, and includes a brief résumé of diseases often associated with systemic hypertension, namely:

chronic diffuse glomerular nephritis, toxemia of pregnancy, arteriosclerosis, and diabetes mellitus.

For a better interpretation of the fundus lesions observed in a case of hypertensive vascular disease, the following information is necessary:

Records of the systolic and diastolic blood pressure.

A history of the onset of hypertension, whether mild and gradual, or sudden and accelerated.

Laboratory reports on the urine and blood.

Presence of headaches, nausea, and visual disturbances.

Whether or not there is a history of hereditary hypertension.

The fundus lesions may be stationary, progressive, or retrogressive, depending on the degree and consistency of elevation of the systolic and diastolic blood pressure; and also on the arteriolar sclerotic involvement of other vital organs, especially kidneys, brain, or heart. Sclerosis is a selective process which may involve parts of vessel walls in various areas of the vascular bed. The internist will find the retinal sclerosis an important diagnostic and prognostic guide, since the vasculature and its surrounding tissue may be directly observed in a way not possible in any other organ.

Some internists regard "essential", and "malignant", hypertension as separate entities, while others consider hypertension a single entity of varying degrees of severity. In several cases under my observation for a period of ten years, the "essential" hypertension existed for eight or nine years, and then developed into an accelerated phase or "malignant" hypertension. Whether this accelerated phase represents another affection superimposed upon the "essential" hypertension, or is a prolongation of the "benign" form, is still under investigation. Extensive records of fundus lesions during the protracted course of hypertension may be valuable in the solution of this phase of the problem.

The treatment of hypertension is directed toward the general vascular disease, and the

associated affections, an important measure being to allay the general nervous irritability.

The hypertensive vascular affections previously mentioned will be briefly described and illustrated.

"ESSENTIAL" HYPERTENSION

"Essential" hypertension is regarded by some authorities as a clinical entity, other diseases not being present to an extent sufficient to account for the symptom of markedly increased and persistent high blood pressure. General arteriolar sclerosis or spasm is usually present. Angiospasm of the small arteries of the eye and other organs, particularly the kidneys, has been regarded as the initial factor in the narrowing of the lumen of these vessels which may eventually result in sclerosis. Some authors consider that the spasm is caused by a vasomotor disturbance due to hyperfunction of the adrenal and other glands; while others maintain that it is due to a toxic factor such as that observed in the toxemia of pregnancy.

Patients with "essential" hypertension ("benign" form) may enjoy normal health for many years, with no discomfort and without needing treatment. The fundus is often devoid of any lesion, although in some cases it will show a mild localized arteriolar sclerosis marked by a slight attenuation of the small arteries or arterioles, a moderate venous engorgement, arching or kinking of veins due to arteriolar venous compression, and sometimes, although rarely, hemorrhages or exudates. The sclerosis is a permanent lesion, while the angiospasm is functional and transitory. The hemorrhages and exudates are generally absorbed, leaving no residue.

"MALIGNANT" HYPERTENSION

"Malignant" hypertension is sometimes considered an independent disease of unknown origin, characterized by an accelerated or an acute onset of hypertension, occurring in young and middle-aged individuals with a protracted high diastolic blood pressure. It is a diffuse arteriolar lesion, of which an arteriolar necrosis is frequently the outstanding pathological feature (Klemperer and Otani¹). Colored microphotographic sections will be shown from a

case of "malignant" hypertension in which a chorio-retinal arteriolar necrosis was present. The arteriolar necrosis was not evident in sections of any other organ. The retinal lesion is called by Wagener² "Retinitis of malignant hypertension".

"Malignant" hypertension is a serious malady because the brain, heart, and kidneys are usually involved. Visual disturbances and fundus lesions are almost always early objective signs. The fundus lesions may be moderate or severe, and are varied in character. The optic disc is at first hyperemic; later the disc and the surrounding retina may be edematous owing to the arteriolar sclerosis and the ischemia. The retinal veins are engorged and tortuous; the arterioles are attenuated and tortuous, and show a prominent central light reflex. There is arching and compression of the veins where they are crossed by sclerosed arterioles, localized retinal thrombosis and hemorrhages, grayish, ill-defined exudates, a star figure in the macular area, choroidal and vitreous hemorrhages and, rarely, detachment of the retina and embolism of the central artery. Edema of the disc and surrounding retina usually signifies a serious involvement of vital organs, especially the kidney, as stated in a previous article of the author.³

Both eyes may show these pathological changes in varying degrees. The prognosis is grave, especially in young individuals; death is caused by renal, cerebral or cardiac involvement, and occurs from a few weeks to two years after the appearance of fundus lesions.

CHRONIC DIFFUSE GLOMERULAR NEPHRITIS

In the early stages of chronic diffuse glomerular nephritis without hypertension, the fundus is frequently normal; later the fundus picture consists of a pale disc, normal retinal vessels, retinal hemorrhages, woolly exudates, and a star figure in the macular area. In advanced cases there may be retinal arteriolar sclerosis.

If a mild protracted hypertension is present in the early stages of chronic diffuse glomerular nephritis, the fundus may show lesions of "essential" hypertension indicative of an arteriolosclerotic kidney.

Fundus lesions observed in the severe form of chronic diffuse glomerular nephritis with "malignant" hypertension may simulate the fundus picture seen in "malignant" hypertension. A previous history of hypertension or nephritis may assist in the differentiation.

Death in chronic diffuse glomerular nephritis is generally due to uremia occurring within three years of the appearance of the fundus lesions. If "malignant" hypertension intervenes, death occurs sooner and may be due to uremia, cerebral apoplexy or cardiac failure.

TOXEMIA OF PREGNANCY

The fundus changes frequently observed in the toxemia of pregnancy are due to toxemia, hypertension, and a complicating nephritis or pyelonephritis. It may be free from any lesion, or it may present moderate or severe "malignant" hypertensive lesions such as angiospasm of the retinal arterioles in isolated areas, arteriolar sclerosis, edema of disc and retina, venous engorgement with tortuosity, hemorrhages, exudates, and retinal detachment. These manifestations often disappear after delivery, leaving no residue unless the condition is complicated by nephritis. In some cases the vision is markedly affected as the result of a transitory amaurosis caused by cerebral toxemia. The pupils are dilated and react to light. With improvement in the general condition the vision usually returns to normal.

If there is a rapid progression of the fundus lesions, with increasing visual disturbances and a marked deterioration of the general physical condition, it may be advisable to terminate the pregnancy in order to safeguard the patient's vision, and even her life.

ARTERIOSCLEROSIS

The vascular lesion, arteriosclerosis, occurs in the aged, and is of unknown origin. It affects the arterial walls of large blood vessels in contradistinction to the affections of smaller

1. Klemperer, P., and Otani, S.: "Malignant Nephrosclerosis" (Fahr). *Arch. Path.*, 11:60, (Jan.) 1931.
2. Wagener, H. P.: The Retinitis of Malignant Hypertension. *Tr. Am. Ophth. Soc.*, 25:349, 1927.
3. Cohen, M.: Significance of Pathologic Changes in Fundus in General Arterial and Kidney Diseases. *Tr. Ophth. Sect., A. M. A.*, 1922, p. 60.

vessel walls seen in arteriolar sclerosis. Arteriosclerosis attacks the larger vessels in the retina, and extends to the smaller arteries and arterioles. Diversified sclerotic lesions of the general vasculature may accompany the retinal sclerosis. The fundus is frequently normal; if changes occur, they are mild, consisting of a pale disc, contraction and tortuosity or corkscrew appearance of the smaller vessels, arteriovenous compression, isolated hemorrhages, and a few grayish minute foci. If a mild or severe hypertension intervenes, the fundus lesions will be similar to those observed in "essential" or "malignant" hypertension, but this combination is rarely seen. Death in arteriosclerosis is usually due to coronary or cerebral involvement.

DIABETES MELLITUS

Diabetes mellitus is a disease of young or middle-aged individuals. Fundus lesions in this condition are frequently evident in the latter class in connection with arteriosclerosis. The fundus findings in so-called diabetic retinitis are the result primarily of the arteriosclerosis, and secondarily of the protracted glycosuria. The fundus picture consists of a slight venous hyperemia, arterial sclerosis, minute circular retinal hemorrhages, and glistening, sharply defined foci. The optic disc is generally normal. If hypertension accompanies diabetes mellitus, the fundus may assume, in addition, the vascular lesions observed in "essential" and "malignant" hypertension, but this combination is rare.

29 East 64th Street

THE SIGNS AND SYMPTOMS OF AGING AND ITS TREATMENT

By CHRISTIAN P. SEGARD, M.D., Leonia, N. J.

That the span of life is lengthening is reflected in the increasing number of the population over fifty years of age. It is also reflected in the increasing mortality rate of those diseases commonly associated with advancing years. Some of these conditions are not necessarily fatal, need not require radical treatment, and can be prevented from becoming a disabling condition by palliative measures that will make the patient comfortable if not affording complete relief. Few expect to be, or can be, cured. Comfort is their objective.

GERIATRIC CONDITIONS

The common signs and symptoms of age are:

1. Loss of tonicity of the sphincters (rectal, urethral, oral).
2. Stasis (biliary, colonic, vaginal, prostatic).
3. Loss of elasticity (skin, circulatory, lens, membranous).
4. Tooth loss and alveolar absorption.
5. The disappearance of sub-cutaneous fat.
6. Endocrine imbalance.

Many conditions, such as hemorrhoids, arthritis, heart and coronary conditions, and flat feet are distressing to the aged individual; but these conditions are somewhat similar at all ages; or are in the field of already established specialties.

MENTAL STATES

The mental state of these aged patients is an important consideration. The accumulation of years of mental experiences cannot but leave some persisting evidence of thought and habit, and of fad or mental deviation. These may be brought to a verbal recognition if not too deeply imbedded. They may be learned from a closer association, or from relatives.

CONSTIPATION

Constipation in the older group is similar to the condition in earlier years, namely:

1. Lack of sufficient fluid intake.
2. Character of the food.
3. Bad habits.

Increase of fluid intake by the use of fluid

foods (milk, soup, fruit juices, vegetables) may correct the first condition. If it does not, two glasses of hot or cold water containing a gram of table salt each, taken on arising, has proven of value. Every "call" (sigmoid and rectal feeling of fullness) should be answered, whether there are results or not; there soon should be results. Mineral oil used too frequently leads to rectal seepage. It is a fallacy to say that one bowel movement a day is satisfactory. No animal (except the human) can do well at that level.

Since *muscle tone* is lessening in the aged, it is natural to expect a similar condition to be present in the gall and urinary bladders, and in the prostate, as well as in the intestinal tract. The bowel condition is met with increased fluid intake (provided there are no contra-indications). The stasis of the gall and urinary bladders may be met in a similar manner,—that is by an excess of water for the urinary bladder, and increased bile intake for the gall-bladder. By this method we dilute the highly concentrated residual fluid present, and decrease the amount of solid matter remaining as an irritant.

THE PROSTATE

The prostate becomes particularly annoying at times. Frequent emptying up to 45, occasionally to 55, and infrequently after 60 or 65, it now becomes an organ needing attention. If not emptying normally, it should be emptied by massage. Before being certain that it is a hyperthrophied prostate, it is well to empty it by massage, and then determine the extent of a hyperthrophy and its possible effect. But be certain you are reaching the prostate. Not every physician has a finger long enough to reach it, let alone massage it.

LOSS OF ELASTICITY

Loss of elasticity of various tissues is associated with age, and but little can be done about it. Nevertheless, it would seem that an earlier dietary change may have some effect. High cholesterol intake seems to be related to loss of elasticity in the lens of the eye, and in the capillaries. Whether the gradual decrease in endocrine support, or whether the lower pro-

TECTIVE food intake is the cause, is simply conjecture. Decreasing the cholesterol, and increasing the endocrine and protective food factors, is sound therapy in any case.

MOUTH CONDITIONS

Tooth decay, tooth structure exposed below the normal gingival margin, alveolar absorption, tooth loss, and artificial dentures, are of vital importance. If the oral cavity is abnormal in any respect, the action of the mouth on the food is changed. The amount of food intake is sometimes lowered below the normal level of support because of an existing oral pathology. It becomes inconvenient, or even uncomfortable and painful to eat. Hence not enough food. The amount may remain the same, but it is insufficiently masticated.

If the "bite" is poor, the teeth may be tender, or the denture may need rebasing. In any case, the food is bolted and leads to changes in the intestines and in the organism. These oral conditions, along with a dietary fad or two so frequently seen in the aged, combine to make up the larger part of these cases. Improper diet over many years results in ills of the middle-aged as well as of the aged.

ENDOCRINE CONDITIONS

Changes in the endocrine system are responsible for many variations in tissue change. Some are evidently of a reversible nature, and respond to hormone therapy. But hormones in this field are best used to gradually taper off the change from apparently decreasing endogenous production, to an almost complete cessation and accompanying senescence. The shift from endogenous to exogenous may be abrupt, or gradual, according to the condition; and the therapy may be of the ascending or descending dosage.

Senile vaginitis responds to estrogenic therapy. It has also been shown to respond to lactose. (Roblee, M. A. Jour., Missouri Med. A., 34:285, Aug., 1937.)

B. coli and trichonoma vaginitis infections in older women are no doubt due to carelessness and uncleanness at stool. This is the most frequent cause of this type of infection.

MENTAL PROBLEMS

Since with age there is a decreasing hormone production, there are concurrent mental problems. The strain is frequently not too great or too noticeable. In some cases there is an upheaval that will need the frequent attention of the physician. The problem resolves itself into a choice of hormone, or sedative therapy, or both.

Sedatives are also frequently necessary to produce a more profound sleep than some of the older persons seem to have. The afternoon nap of the aged is sound therapy, if it does not interfere too much with the night's rest. Coffee and caffeine drinks in excess, and before bedtime, may be responsible for the night's unrest.

In the Winter, use cotton blankets for sheets. Cold sheets are a hardship. Cotton blankets are cheap and easily cleaned, and any shifting at night does not bring another cold spot in contact with the body already losing heat.

DIET

In addition to the remarks on food in connection with oral conditions, a satisfactory protective food diet similar to that of the child seems best. While the aged do not need the high caloric diet of the child, they do need a

simple one. It should contain milk of a high vitamin content, and no doubt some cream also, since the subcutaneous fat should be maintained if possible.

Like children, older people indulge themselves in their foods; and when the family objects, they do it unseen. Sweets and coffee to excess and the natural loss of appetite for protective foods is the result. Just like children. Correct nutrition of the aged is highly important (Tonby, E. L., Jr. A. M. A., 114:223, 1940). Some restriction is necessary, however, if there are oral, tooth, intestinal conditions, or if the life is a sedentary one.

ACCEPTING OLD AGE

It has been intimated that few would admit of attaining an age that would put them in the hands of the Geriatrician. This psychological attitude can be overcome. The infirmities and the degenerative diseases, as well as the signs and symptoms of age, may be postponed by an early recognition of tissue change. This change will no doubt appear where early infectious diseases have left their mark. Medicine can ease the infirmities and postpone the signs. Geriatrics may well adopt "Retaining our youth after 50" as its objective.

PREMATURE RUPTURE OF THE MEMBRANES

MATERNAL WELFARE ARTICLE NUMBER FIFTY-SIX

By WILLIAM HEATLEY, M.D., Red Bank, N. J.

By premature rupture of the membranes we mean an expulsion of liquor amnii before the onset of labor pains. Labor follows in most cases within three or four days; however, De Lee has recorded one case in which labor was delayed ten days, while other investigators record a lapse of time up to fifty days but lacking microscopic proof of the early rupture. The escape of fluid prior to the onset of uterine contractions may be due in some instances to discharges from between the chorion and uterine wall, commonly known as *hydorrhea gravidarum*. Also in other cases it may be due, not to a frank break of the membranes at the

internal os, but to a leak high up in the bag. With the premature rupture there may be a gush of a large quantity of amniotic fluid, but rarely does all the fluid escape. There may be dribbling for several hours, or several days, before all the fluid is lost. A truly dry labor is an exceedingly rare complication.

Premature rupture of the membranes is not necessarily due to any intrinsic peculiarity of the membranes, such as abnormal thinness, but more frequently it is due to anomalous conditions elsewhere (called by De Lee mechanical maladaptation of the presenting part to the cervix), i. e., contracted pelvis or malpresentation.

These conditions are not necessarily dystocic, because in most instances the amniotic fluid does not all escape. Labor may be somewhat tardy, but not definitely so.

The loss of the water wedge before completion of dilatation brings the head of the fetus in direct contact with the cervix. This tends to induce a tetanic action of the uterus and cause injury to the cervix. It becomes greatly elongated, and the anterior lip very edematous. In such cases laceration is extremely frequent.

Likewise there is marked compression of the fetal head causing a tendency to asphyxia and intracranial hemorrhage. The tetanic action of the uterus combined with the edematous cervix retards the first stage of labor and exhausts the mother. The fetus can stand the pressure of labor for a great length of time indifferently so long as the amniotic fluid equalizes the pressure; but when the waters have escaped, it suffers in proportion to the duration of labor and the severity of the uterine contraction. A very serious complication in these cases is the prolapse of the umbilical cord, which allows for no temporizing.

Per Wetterdal observed 1,022 patients in whom there was premature rupture of the membranes, before the onset of labor pains. In one group of patients, labor was short, and there were few complications; in a second group delivery was delayed and there were numerous complications. The investigator believed that the complications in the second group were due not to the premature rupture of the bag of waters, but to the ineffectual labor pains.

Contrary to the general belief regarding labor, when there is a premature rupture of the membranes, P. Endres and H. Guthman found that analysis of these cases revealed that rupture of the membranes, before the onset of the pains, shortened labor. This they found true when pregnancy was terminated pre- or post-maturely. Shortening of labor takes place during the first stage, hence the absence of the bag of waters not only does not influence the period of dilatation unfavorably, but really helps dilatation in many cases. The reason for this, in the opinion of the authors, is the absence of resistance which is present when a hydrostatic pressure is exerted by an intact bag of waters. On the other hand, they found that rupture of the membranes after the onset of labor pains, but before complete dilatation of the cervix, prolonged labor. In these cases the increase in labor is due particularly to a lengthened first stage, the cause for this being attributed to a temporary atony of the uterus which follows the rupture of the membranes.

As regards treatment of the case with premature rupture of the membranes, the interest of both the mother and baby are best served by non-interference. Most patients should ideally be kept in bed, with sufficient sedation to allay apprehension. All intra-vaginal manipulations should be forbidden in order to lessen the possibility of uterine infection. If labor does not begin within two to three days, and if the fetus is viable, I think the use of castor oil, quinine, and hot enemata to induce labor, are advisable. Rarely will it be necessary to insert an intra-ovular bag for the induction of labor.

A LESSON FROM A DEATH CERTIFICATE

NUMBER TWENTY-EIGHT

Grav. v, para iv. Patient attended by midwife. No prenatal care although urged by midwife to go to clinic.

Had a severe hemorrhage at beginning of labor. Stillbirth followed by shock. Sent to hospital where she was given a transfusion (direct method) and infusion of saline and glucose and acacia but remained listless. Hemoglobin 60 per cent. Eight days after admission

hemoglobin was 40 per cent and another transfusion (citrate method) was given after which patient became rapidly worse and died in three hours.

1. How can midwife cases be provided with proper prenatal care?

2. How can transfusion shock be avoided?

A. W. BINGHAM.

STATE SOCIETY ACTIVITIES

ANNUAL REPORTS TO THE HOUSE OF DELEGATES

The time of preparing the annual reports to the House of Delegates is fast approaching. As in past years, the reports will be received and handled by the Executive Officer.

This year the Annual Meeting will be held on May 20, 21, and 22,—two weeks earlier than last year. It will, therefore, be necessary that the reports shall be submitted promptly, according to the following schedule:

1. OFFICIAL NOTICE

Early in March a notice will be sent to each officer, committee chairman, and county society president, reminding him to:

- a. Prepare a report of the year's work; and
- b. Send it to the Executive Officer on or before April first.

2. APRIL FIRST

The Executive Officer and the Editor will:

- a. Send each report to the printer to be set in type; and
- b. Send a proof to the author of the report as soon as possible.

3. APRIL FIFTEENTH

Proof corrected or approved, shall be returned by the author to the Executive Offices on or before April fifteenth.

4. APRIL TWENTIETH—MORNING

Each sub-committee of the Welfare Committee shall hold a meeting on the morning of April twentieth in order to formulate its final report, including such recommendations from its advisory committees' reports as it approves.

5. APRIL TWENTIETH—AFTERNOON

Each sub-committee shall submit its final report to the Welfare Committee for consideration and approval.

6. The reports will be printed in the May Journal.

7. This schedule must be dispatched on time, so that on May first preprints of the annual reports shall be ready for distribution to the members of the House of Delegates.

LEROY A. WILKES,
Executive Officer.

ADVISORY COMMITTEE ON TUBERCULOSIS

A meeting of the Advisory Committee on Tuberculosis was held on January 3rd, 1941, in the Academy of Medicine, Newark, New Jersey. Those present were: Dr. Jaffin, Chairman; Drs. J. E. Morrow, B. S. Pollak, S. B. English, and N. W. Burritt. Also present were Drs. B. M. Harman, A. M. Kallen, A. L. Kruger, C. H. Schlichter, N. M. Scott, and L. A. Wilkes, and Lieut. Soloman.

Subject: Tuberculosis aspects of physical examinations of Army draftees.

After discussion of the classification procedure followed in the chest examinations and the x-ray diagnosis on draftees, it was unanimously agreed that standard classifications such as are recommended by the National Tuberculosis Association be followed. These are consistent with the classifications recommended by the Army.

The committee unanimously approved the N. T. A. tuberculosis nomenclature, and urged that it be followed in recording the diagnoses. Where this is not possible the records should

definitely state that the picture showed evidence of subnormality "cause undetermined".

Where cases are definitely tuberculous, Dr. Mahaffey, of the Department of Health, wishes these cases reported to that department.

Dr. Jaffin pointed out that the responsibility of the examiners extends beyond the military acceptance or rejection of the individual examined, and that the diagnosis should be sufficiently refined, in accordance with the recommendations of the N. T. A., to provide for civilian follow-up and treatment of these cases. This improved diagnosis would also enable the War Department to reply to requests for diagnoses on these cases in the distant future as well as at present.

Members of the Tuberculosis Committee who could possibly do so were invited by Dr. Jaffin to meet on January 9th at 3:00 p. m. at the Sussex Avenue Armory in Newark to review the chest films of those diagnosed (twenty-two in number) with the idea of improving the recorded diagnoses.

The Somerville Induction Board is now closed, and the films from that station are in the Newark Armory. The films from the Trenton Board are in Dr. Scott's office.

As a point of information, Dr. Scott stated that it is the aim of the Federal authorities to make available from among the Reserve Officers those who might be called "Chest experts" to serve on the permanent induction board at Fort Dix, and to be used when the building is ready for occupancy. The present boards in the Second Corps Area will then be closed, and all examinations held at Fort Dix.

Dr. English moved that the committee endorse the training of Reserve Officers (M.D.'s) for reading chest films, this training to be given at the State and County Tuberculosis Hospitals. Seconded by Dr. Burritt, and unanimously carried.

The members of the committee who are heads of sanatoria were asked if the facilities of these sanatoria might be used for the training of selected enlisted men as x-ray technicians. This procedure was approved, if the men will agree to stay long enough for adequate training. No responsibility is assumed

by the sanatoria, as this is an emergency offer on the part of the sanatoria directors in response to a request for training x-ray technicians for the Army. The committee unanimously endorsed this proposal.

X-RAY COSTS

Dr. Scott reported that the Army agreed to pay for the services of two technicians, one clerk, and one messenger for each induction center where the x-ray pictures are not taken by the Powers organization, with whom a separate contract is involved. The Powers Company sends the bills directly to the Second Corps Area, but the bills for the other films (75 cents each) are sent through Dr. Schlichter, Chairman of our Medical Preparedness Committee.

The additional x-ray technicians are needed beginning January 6th. Dr. Scott, with the help of Drs. Pollak, Morrow and English, will see that these technicians are provided.

The meeting was adjourned at 5:30 p. m.

LEROY A. WILKES, M.D.,
Secretary.

GRADUATE COURSES

The Newark City Hospital.—New York University College of Medicine announces a change in admission requirements for the post-graduate course in amputations at the Newark City Hospital, in response to requests from New Jersey physicians. The course is now open to any member of the visiting surgical staff of a hospital recognized by the American College of Surgeons; as well as to Fellows of the American College of Surgeons, and to Diplomates of the American Board of Surgery.

The course will include lectures, cadaver work, and case presentations demonstrating the recent advances in the surgical treatment and the after-treatment of amputations. Particular attention will be given to prosthetic appliances.

Sessions will be held on seven successive Saturdays from March 1st through April 12th.

Tuberculosis.—The University also announces a fifth new post-graduate course this Spring at the Newark City Hospital,—a clinical course in tuberculosis. It will be held Monday and Thursday afternoons, from four-thirty to six o'clock, from April third through May twelfth. The course will consist of twelve lectures devoted to the history, bacteriology, epidemiology, pathogenesis, and pathology of tuberculosis; childhood tuberculosis; occupa-

tional pulmonary disease; and the diagnosis and treatment of pulmonary tuberculosis. Clinical material will be available for instruction.

Diseases of the Liver.—In the University announcement, there is also included mention of the post-graduate course in diseases of the liver and biliary tract which will begin at Newark City Hospital on February 25. It will afford the general practitioner a comprehensive review of the diseases, including recent advances in diagnosis and treatment.

The Office of the Dean, New York University College of Medicine, 477 First Avenue, New York, N. Y., will supply application blanks and additional information concerning these courses, and details of other graduate and post-graduate courses.

Bergen County.—The Bergen County Medical Society will conduct a post-graduate course of lectures on peripheral vascular disease, on Thursday afternoons, from 4:00 to 5:30 o'clock, February 6, 13, 20, 27, and March 6 and 13, at the Englewood Hospital.

Dr. Irving S. Wright and his associates from the New York Post-Graduate School of Columbia University are the lecturers.

This course is open to physicians outside of Bergen County, but they will be required to pay an enrollment fee.

THE STATE SOCIETY AWARD, 1941

The Medical Society of New Jersey has authorized an award of one hundred dollars for the best essay on an original medical subject, submitted according to the following rules:

1. Any medical or surgical subject may be selected.
2. The essay must be unpublished and of interest to the general practitioner.
3. Contributions must come from members of the Society who are in good standing.
4. The manuscript must not exceed 5000 words; and shall be typewritten in English, in manuscript form, with double spacing, wide margins and be

written on one side of the page, and five copies shall be submitted.

5. Manuscripts must be in the office of the Secretary of the State Society, Dr. Alfred Stahl, 55 Lincoln Park, Newark, N. J., not later than April 15, 1941.

6. The winner shall be determined by a secret Awards Committee composed of five members of The Medical Society of New Jersey. The officers of the State Society are not eligible for the award.

7. The winner shall be awarded a cash prize of \$100; and an invitation to present the contribution before the 1941 Annual Meeting of the State Society.

8. The Society reserves the right to make *no award*, if in the judgment of the committee no contribution is desirable.

ASSOCIATION OF MILITARY SURGEONS

The Association of Military Surgeons of the United States is sponsoring a program on "Medico-Military Preparedness" throughout the country. The idea is to bring to the medical, dental, and nursing professions of the country an idea of their responsibilities to the government, in these days of unrest, and to correlate civilian practice with that of the Army, the Navy, and the Public Health Ser-

vice. The coöperation of the various State and County Societies is being cheerfully given toward an instructive program which we hope will be of much benefit in promoting the "all out" coöperation of the profession in general.

H. D. CORBUSIER,
Col., Med. Res. Corps, U. S. Army,
Pres., Association of Military
Surgeons.

AVIATION MEDICINE

The February 20, 1941, meeting of the New Jersey Chapter of the Association of Military Surgeons will be devoted to a symposium on Aviation Medicine. The meeting will be held at Hotel Douglas, 15 Hill Street, Newark. The discussion will be led by Lieut. Commander J. F. Neuberger, M.C., U.S.N., executive medical officer, Third Naval District. Lieut. Colonel Louis A. Lipton, Med.-Res., flight surgeon and Surgeon, Third Military Area, will talk on physical standards for the air service.

Members of the medical profession, civilian physicians as well as those in the Army and Navy Reserves, and other allied professional groups interested in the subject are invited. The meeting is scheduled for 8 o'clock. An informal dinner will be held at the Douglas prior to the meeting (7 o'clock). Those desiring to attend the dinner are requested to so advise the Chapter secretary, Lieut. Colonel A. G. Hulett, 20 Hawthorne Avenue, East Orange; phone Orange 4-0633.

AMERICAN COLLEGE OF SURGEONS

A sectional meeting of the American College of Surgeons, embracing New Jersey, New York, Pennsylvania, Delaware, District of Columbia, Maryland, Virginia, West Virginia, and Ohio, will be held in the William Penn Hotel, Pittsburgh, Pennsylvania, on March 17, 18, and 19, 1941.

Hospital conferences will be held in connection

with each of these meetings. Fellows of the College, members of the medical profession at large, and persons interested in the institutional care of the sick and injured, are invited to the Sectional Meetings. On the final evening of each meeting, a Meeting on Health Conservation, to which the public is invited, will be held.

MEDICAL PREPAREDNESS QUESTIONNAIRE

In the early Fall, about one-half of the physicians of New Jersey had filed their personal returns regarding their availability for service in some department of military preparedness. The January issue of the Ohio State Medical Journal, page 59, contains the following table of the percentage of the returns for eleven States up to December 18, 1940:

	Per Cent
Indiana	96
Ohio	88
California	82
Texas	81
Missouri	78
New Jersey	75
Illinois	73
Michigan	73
Pennsylvania	65
Massachusetts	63
New York	61
The U. S. A.	74.3

In September, 1940, 52 per cent of the recorded physicians of New Jersey had filed their personal returns. A canvass by return envelope in October resulted in additional reports from over 600 physicians. There still remain about 25 per cent of the physicians who have not filed returns. It is probable that the majority of those not making returns are not eligible for full military duty; but they may be able to attend patients for a physician who is in the Army or Navy; or to serve at least in some capacity in hospitals and clinics, and thereby relieve a younger physician for full military service. It is therefore essential that every individual physician licensed in New Jersey shall be listed.

The Medical Society of New Jersey will mail a letter and reply envelope to those who have not yet made their returns. Those who still make no reply will be reached by the County Societies, so as to obtain a record of every physician, young or old.

REPORT OF THE SALEM COUNTY SOCIAL DISEASE CLINICS FOR THE YEAR 1940

By FRANKLIN H. CHURCH, M.D., Salem, N. J., Chief of Clinics

In the past year the usual five weekly clinics have been held,—three afternoons in Salem, and two in Pennsgrrove. No clinics were missed except six in Pennsgrrove owing to a fire in the clinic building, the Old Moose Hall.

Three thousand, nine hundred and forty-two treatments were given in the Pennsgrrove clinic, and 4,038 in the Salem clinic.

In the Pennsgrrove clinic there were admitted 23 new cases, 17 colored and six white.

In the Salem clinic there were admitted 87 new cases consisting of 32 colored males, 50 colored females, two congenital white males, one white male, and two white females.

The number of new cases discovered is quite in excess of the preceding few years, but depends on the fact that two more of our large industries have established a rule requiring a blood test before employment—the H. J. Heintz Company, and the Anchor-Hocking Company.

Statistics are seldom interesting, but at the risk of your boredom, I am going to detail the results and significance of a series of 338 blood Wassermann tests coming under my observation from July 1st, 1940, to October 1st, 1940. These figures in no way indicate the percentage of the disease present in a cross-section of the population of Salem County but rather demonstrates that among individuals employed in a certain type of labor. Some years ago the tests which were taken by the DuPont Dye Works on a large series of employees showed a percentage for the entire group of white and colored employees of 7.3 per cent. The percentage generally admitted to exist in the native white population of the country is three per cent.

In our series of 338 tests, 55 were white and 283 were colored. Of the 55 white tests, seven were positive, or 12.7 per cent.

Of the 283 colored, 202 were negative and 81 positive,—a percentage of 28.

Of the 88 positive cases, only two came

within the classification of early latent syphilis, and could be regarded as contagious.

In the white group, there were three positive males and four positive females. In the Negro group there were 36 positive males, and 45 positive females. The usual figures are shown to have a predominance of infected males since the female seems to be more skilled in avoiding detection and control. This would also tend to indicate the fact that the examinations were for the usual type of canning house labor, rather than a cross-section of the general population.

Of the Negroes giving their birthplace as Salem County, 20 per cent had positive Wassermanns. Of those stating that they were born in New Jersey but outside of Salem County, 22 per cent had positive tests. Of those who stated that they were born in some other State, 133 tests, 31 per cent had positive tests for syphilis.

When these figures are broken down in age groups in the Negro we find the following:

Age Group; Yrs.	No. Tested	Positive	% Positive
15-20	63	7	11
20-25	66	15	23
25-30	47	14	30
30-35	32	12	37
35-40	22	7	32
40-45	33	18	55
45-50	11	4	36
50 plus	9	4	44
	283	81	

It is possible to deduce, from this small series, in age groups, that apparently there is not now so much active transference of syphilis in the younger age groups, owing to the fact that the work of the clinics prevents the spread of the acute disease.

Of those Negroes whose marital status was recorded, the single group gave 23 per cent positive blood tests for syphilis. The married group demonstrated 42 per cent positives. Thus again the younger and unmarried group are shown to be less infected with the disease.

As showing the menace of the migratory

laborer as a spreader of syphilis, the following clinical experience is related. In the Spring, a fifteen-year-old colored girl came to the pre-natal clinic and was found to have a positive blood test. She belonged in a group of asparagus cutters who had come up from the South and had settled below Canton. There were thirteen others in the group and when brought into the clinic and examined were found to be 50 per cent infected. They received about five months' treatment, and then left for the South with the ending of the active season.

The antisyphilitic drugs used in the clinic are supplied by the State Bureau of Venereal Disease control with the aid of the United States Public Health Service; and no patient is ever refused treatment in the county clinics.

As for the past five years Dr. H. F. Suter served this year as a volunteer assistant in the Pennsgrove clinic; while in the Salem clinic Dr. A. S. Mason served as a paid assistant.

At the Salem County Home for the year of 1940, 163 visits were made by the attending physician; and 450 treatments, comparable to the usual clinic treatment, were given.

Clinics have been held in Salem County, especially at the Memorial Hospital, since about 1927. Eight years ago the DuPont Dye Works established routine tests on all its employees, for the managers were convinced of their value, both as a social welfare project among their workmen, and also as a method of avoiding accidents by keeping syphilitic brains away from responsible positions and dangerous throttles. This has since extended until all its employees, in all its plants in the country, are subject to the same rule. The DuPont Company has its own plant tests all performed in its own laboratory. The rule established is that any man may work in the plant even if he does have a positive Wassermann test, but he must take his treatments or be discharged. Acute syphilis or gonorrhea is a sufficient cause for a sick leave until the patient is cured, or is no longer contagious. Other plants in the county are following this example until now a large percentage of all industrially employed men and women are examined annually.

REPORT OF THE ARMY INDUCTION BOARDS

The two Induction Boards of the Army—those at Trenton and Newark—examine those selected men who are referred by the 202 Local Selective Service Examining Boards for induction into the Federal Service.

The Induction Boards submit the following report of their examination of referred men from January 6 to January 17, 1941. It is a two-week cross-section of the routine work of the Boards, and indicates the practical nature of their work in deciding doubtful cases.

1. SUMMARY OF MEN EXAMINED

Number Selectees examined	2473
Number rejected for medical causes	435
Number rejected for non-medical causes	27
Total Selectees rejected	463
Total Selectees inducted	2010
Percentage of rejections	18.7

2. MEDICAL CAUSES OF REJECTION

TEETH	94
EYES	75
Vision	70
Physical defects	5
EARS	44
Perforated drum	27
Otitis media	14
Other conditions	3
NOSE AND THROAT	31
Nasal septum deviation	15
Rhinitis	4
Sinusitis	3
Tonsillitis	5
Miscellaneous	4
HEART	23
Valvular	9

Hypertension	8
Tachycardia	3
Brachycardia	2
Hypertrophy	1

NEUROLOGICAL AND MENTAL

Chronic alcoholism	8
Criminal record	12
Epilepsy	4
Imbecility	10
Psychoneurosis	8
Psychopathic constitutional state	6
Sclerosis, multiple	2
Insanity, mental deficiency, morally unfit, neuritis, neurasthenia, paresis, paralysis agitans, postencephalitic, stuttering, syphilis—1 each	10

GENITO URINARY

ORTHOPEDIC

PULMONARY

Tuberculosis	20
Asthma	6
Bronchitis	4
Pleurisy	5
Pertussis	1
Influenza	1

GASTRO-INTESTINAL

Ulcer	1
Appendicitis	1
Hemorrhoids	2

METABOLIC

Diabetes mellitus	3
Hyperthyroidism	1

HERNIA

Inguinal	9
Postoperative	5
Umbilical	2

SKIN

Cellulitis of finger	1
Varicose veins	2

THE NEW JERSEY GASTRO-ENTEROLOGICAL SOCIETY, INC.

The New Jersey Gastro-Enterological Society held a symposium on "Lesions of the Stomach, Duodenum, and Jejunum", at the Academy of Medicine, Newark, N. J., on Monday evening, February 3rd, 1941.

Dr. Hyman I. Goldstein, Camden, N. J., President, presided at this meeting.

Participants were: Dr. William T. Lemmon, Jefferson Medical College; Dr. Burrill

B. Crohn, Mount Sinai Hospital, New York City; Dr. Karl Kornblum, Jefferson Medical College, Professor of Radiology, Philadelphia, Pa.; Dr. Isidore S. Ravdin, Professor of Surgery, University of Pennsylvania; Dr. John H. Garlock, Mount Sinai Hospital, New York City, and Dr. Charles L. Brown, Professor of Medicine, Temple University, of Philadelphia, Pa.

BOARD OF MEDICAL EXAMINERS

E. S. HALLINGER, M.D., F.A.C.S., Secretary, Camden, N. J.

Following is a report of the Board's work in enforcing the Medical Practice Act since our last report (Journal, September, 1940, page 479):

June 20th, Max Messing, a masseuse of Jersey City, who was found guilty of practicing medicine without a license on February 29th, 1940, was sentenced to one day in jail in lieu of the penalty.

August 9th, Joseph West of Camden, an unlicensed chiropractor, paid the penalty for practicing medicine without a license to the Clerk of the Camden District Court. This was a third offense.

August 16th, Charles Schaefer, Jr., of Oaklyn, was arrested for the third time and paid the penalty to the Court. On the same day Charles Schaefer, Sr., was arrested for the sixth time and paid the penalty to the Court. The Schaefers practice by means of laying-on-of-hands.

September 17th, Bertha Golembiewska of Linden paid the penalty to the Attorney General for continuing to practice midwifery without having obtained an annual certificate of registration.

September 17th, Sadie Spinner of East Orange, an unlicensed chiropractor who also gave medicine, was tried before Judge McMahon of the First District Court in Newark and decision reserved. Decision was rendered in favor of the defendant on October 1st.

October 22nd, Joseph Tulliglowicz of Newark, a naturopath, was tried before Judge McMahon of the First District Court in Newark and found guilty of practicing medicine without a license.

October 22nd, Max W. Friedman of Newark, a registered pharmacist, was tried before Judge McMahon of the First District Court in Newark, and found not guilty.

November 13th, Randal J. Brown of Trenton, a registered pharmacist, paid the penalty to the Attorney General for practicing medicine without a license.

December 10th, Wellington A. Allen, a colored man of Plainfield who posed as a doctor, pleaded guilty in the First District Court in Elizabeth, and was sentenced to ten days in jail.

December 11th, Andrew V. Pulcrano of Lakewood, who was found guilty of practicing medicine without a license July 26, 1939, paid his penalty to the Attorney General.

December 20th, Frank Crawford of Williamstown, a registered pharmacist, paid the penalty for practicing medicine without a license to the Court of Common Pleas of Gloucester County.

December 30th, Florence Goldstein of Passaic, an herbalist, paid the penalty to the Attorney General for practicing medicine without a license.

January 8th, Francis X. Halligan of Toms River, a registered pharmacist, paid the penalty to the Attorney General for practicing medicine without a license.

January 8th, Harold Singer of Jersey City, a licensed chiropractor who exceeded his license by giving electric treatments, manipulation, and adjustments, paid the penalty for practicing medicine without a license to the Attorney General.

The time of day I do not tell,
As some do, by the clock,
Or by the distant chiming bells
Set on some steeple rock,
But by the progress that I see
In what I have to do.
It's either Done o'Clock to me,
Or only Half-past Through.

—JOHN KENDRICK BANGS.

OBITUARIES

DR. FRANCIS ASBURY APGAR

Dr. Francis Asbury Apgar, aged 89, Dean of the Hunterdon County physicians, died on Monday morning, December 30, 1940, at his home in Oldwick. Dr. Apgar was born on July 23, 1851, in Oldwick. He graduated from the Bellevue Hospital Medical College in 1876, and ever since that time he has practiced in or near Oldwick.

Dr. Apgar's early practice was in the best tradition of the horse-and-buggy doctor. Dr. Apgar was said never to have refused a call. He made his rounds in a buggy when the weather and the condition of the roads permitted. When snow covered the lanes, he packed his instruments in a saddle bag and rode horseback or walked even though his patients lived many miles away.

The Journal of August, 1937, page 537, contains a photograph of Dr. Apgar on the occasion of his

receiving a certificate of honor for having practiced for over half a century.

DR. ELTON S. CORSON

Dr. Elton S. Corson, of Bridgeton, Cumberland County, died on January 5, 1941. He was born in Marmora, Cape May County, May 4, 1867. He attended Bucknell College and graduated from the University of Pennsylvania Medical College in 1895. He interned in the Polyclinic Hospital, Philadelphia, and practiced in a mission hospital in Toungoo, Burma, for many years. He served in the World War and was a member of the Shoemaker Post, American Legion. He practiced in Bridgeton in recent years, and was an active member of the Cumberland County Medical Society and of the Welfare Committee of the State Society, and was the official reporter for the Cumberland County Society, and often wrote verses of merit.

DECEASED PHYSICIANS—NEW JERSEY

Name	Age	Date of Death	Place of Death	Residence	Cause of Death
Francis A. Apgar	89	Dec. 30, 1940	Oldwick	Same	Uremia.
Grant P. Curtis	55	Aug. 28, 1940	New York	Union City	Gastric ulcer.
Carlo D. Martinetti	62	Dec. 9, 1940	Orange	Same	Cerebral hemorrhage.
Immanuel Pyle	65	Dec. 30, 1940	Jersey City	Same	Fractured skull from fall.

NUMBER OF CHILDREN REPORTED RECEIVING FREE STATE BIOLOGICALS
SINCE JULY 1, 1940

DIPHTHERIA TOXOID

County	Total to Nov. 30	Month of Dec.	Total to Dec. 31	Average per Month
Atlantic	6779	166	6945	1157.5
Bergen	1127	266	1393	232.1
Burlington	85	22	107	17.8
Camden	684	352	1036	172.6
Cape May	18	2	20	3.3
Cumberland	62	7	69	11.5
Essex	3991	662	4653	775.5
Gloucester	60	6	66	11.
Hudson	817	748	1565	260.8
Hunterdon	9	16	25	4.1
Mercer	867	381	1248	208.
Middlesex	338	29	367	61.1
Monmouth	916	18	934	155.6
Morris	360	18	378	63.
Ocean	15	20	35	5.8
Passaic	2629	189	2818	469.6
Salem	171	30	201	33.5
Somerset	166	39	205	34.1
Sussex	1	2	3	.5
Union	1033	139	1172	195.3
Warren	47	3	50	8.3
Totals	20175	3115	23290	3881.6

SMALLPOX VACCINE

County	Total to Nov. 30	Month of Dec.	Total to Dec. 31	Average per Month
Atlantic	563	67	630	105.
Bergen	911	61	972	162.
Burlington	216	1	217	36.1
Camden	1191	68	1259	209.8
Cape May	41	12	53	8.8
Cumberland	122	2	124	20.6
Essex	3499	1123	4622	770.3
Gloucester	192	6	198	33.
Hudson	1896	304	2200	366.6
Hunterdon	20	1	21	3.5
Mercer	813	23	836	139.3
Middlesex	572	34	606	101.
Monmouth	343	4	347	57.8
Morris	444	37	481	80.1
Ocean	11	10	21	3.5
Passaic	1749	74	1823	303.8
Salem	232	1	233	38.8
Somerset	120	6	126	21.
Sussex	21	0	21	3.5
Union	1003	28	1031	171.8
Warren	185	3	188	31.3
Totals	14144	1865	16009	2668.1

COUNTY SOCIETY REPORTS

COUNTY SOCIETY COMING MEETINGS

FEBRUARY, 1941

4 Camden	13 Passaic
4 Hudson	13 Somerset
11 Bergen	14 Atlantic with Cape May as guest
11 Cumberland	19 Middlesex
12 Mercer	20 Gloucester
12 Ocean	21 Salem
13 Burlington	26 Monmouth
13 Essex	

MARCH, 1941

4 Camden	13 Passaic
4 Hudson	13 Somerset
11 Bergen	14 Atlantic
11 Cape May	19 Middlesex
12 Mercer	20 Gloucester
12 Ocean	20 Morris
12 Union	21 Salem
13 Burlington	26 Monmouth
13 Essex	

ATLANTIC COUNTY

Charles Hyman, M.D., Reporter

A combined meeting of the *Atlantic County Medical Society* and the *Atlantic County Dental Society* was held at the Hotel Ambassador, Friday, January 10, 1941. Dr. V. Earl Johnson, President of the Medical Society, presided. Dr. C. William Raith, President of the Dental Society, was introduced to the members.

OFFICIAL VISIT

Dr. Watson Morris, President of the State Society, paid an official visit. He discussed briefly some of the work done by the more important committees.

SCIENTIFIC

Dr. Robert H. Ivy, Professor of Maxillo-facial Surgery, University of Pennsylvania School of Medicine and Post-Graduate School, Philadelphia, addressed the societies on "Surgical Conditions of the Face, Mouth and Jaws". The talk was beautifully illustrated by color photographs of cases before, during, and after treatment. The subjects covered dental lesions of the gums and jaws, tumors benign and malignant, as well as congenital and accidental defects. The paper was discussed by Drs. Barney Barab and Clarence Steigerwald.

After the disposal of some routine business the meeting was adjourned.

BERGEN COUNTY

S. Calthrop Bump, M.D., Reporter

The regular meeting of the *Bergen County Medical Society* was held on October 8, 1940, at Bergen Pines, with President Russell K. Tether presiding.

MEMBERSHIP

Eight applications for junior membership were received.

ANNOUNCEMENTS

President Tether discussed Dr. Norman Scott's talk concerning the Medical Service Administration progress; and the Medical Preparedness activities. Dr. Tether also discussed the School Physicians'

progress; the Mental Hygiene Survey; the Maternal Welfare Committee; and the plans for the Annual Banquet at the Hackensack Elks' Club, November 28, at 8 p.m.

OFFICIAL VISIT

Dr. Watson B. Morris, President of The Medical Society of New Jersey, addressed the society about activities going on throughout the State.

SCIENTIFIC

Dr. J. Arthur Myers, Professor of Medicine at the University of Minnesota, was the speaker of the evening. Dr. Myers went into detail of the microscopic and macroscopic phases of tuberculosis. He brought the desirability of the follow-up of positive reactors to his listeners. It was stated that, with the present methods of tuberculosis control, deaths have been decreased considerably. It is Dr. Myers' belief that the New Jersey program of testing school children will reduce the death rate still further if the follow-up of positive reactors is carried on over a period of years.

The paper was discussed by Dr. John Runnells, Medical Director of the Union County Sanatorium, who recommended that the reactors be x-rayed every three months.

Dr. William Ryan, Medical Director of the Rockland County, New York, Sanatorium, discussed the problem in New York State, in which there are no mandatory laws for testing school children.

Dr. Levitas, Chairman of the Public Health Education Committee of the Bergen County Tuberculosis and Health Association, emphasized the need of constant following up of positive reactors.

A regular meeting of the *Bergen County Medical Society* was held on November 12, 1940, with President Russell K. Tether presiding.

MEMBERSHIP

Two applications for junior membership were received; and four for advancement to regular membership.

Dr. A. L. Gladstone, Paramus, was advanced to regular membership.

The following were elected to junior membership:

John J. Hirsch, Wallington
Herbert G. Miller, Rutherford
E. C. Ravits, Fairlawn
Frank J. Schaberg, New Milford
Irving A. Schultz, Warren Point
Maurice A. Shinefeld, Hackensack

OFFICIAL VISITOR

Dr. Thomas K. Lewis, President-Elect of The Medical Society of New Jersey, was present, and gave a resume of the activities of the State Society.

SCIENTIFIC

Dr. Tether introduced Dr. Charles Mayo, Jr., of the Mayo Clinic, Rochester, Minnesota, who gave a talk on surgical treatment of malignancy of the right colon, based on an experience with 885 cases up to 1938. He spoke of the symptoms which might be those of other diseases and warned the members against the danger of mistake.

Dr. Mayo exhibited a moving picture in technicolor, showing in minute detail the removal of carcinoma of the right intestine.

BURLINGTON COUNTY

T. Bruce Dickson, M.D., Reporter

The regular meeting of the *Burlington County Medical Society* was held on December 9 at the Moorestown Field Club, with 48 members present.

SCIENTIFIC

Dr. Frank W. Konzelmann, Clinical Professor of Pathology at Temple University, gave a scientific address on "Cardio-renal Vascular Disease".

MEDICAL SERVICE PLAN

Dr. Norman M. Scott, Executive Assistant of The Medical Society of New Jersey, described the Medical Service Plan for the care of the low-wage group.

The regular meeting of the *Burlington County Medical Society* was held on January 9, 1941, at the Moorestown Field Club, with forty members present.

The scientific part of the meeting was a sound moving picture entitled "Methods of Contraception", which was presented by the Ortho Products Company. It was not only very interesting and very well presented, but also educational, and a good review of the whole subject.

Mr. Joseph J. Harty, Executive Secretary of the Medical Service Administration, described the plan in detail.

CAMDEN COUNTY

Harold D. Barnshaw, M.D., Reporter

The regular monthly meeting of the *Camden County Medical Society* was held in the City Dispensary Building on January 7, 1941, with 61 members and guests present.

Dr. Asbell and Dr. Samter, recently elected members, took the oath of membership and were introduced to the society.

SCIENTIFIC

The scientific program consisted of an illustrated lecture by Dr. Joseph Vanderveer, on "The Treatment of Cardio-Vascular Disease", with discussions by Drs. Goldstein, Lewis, R. Hollinshed, Decker, and Kain.

MEMBERSHIP

John Phillip Rudolph, M.D., Merchantville, was elected to active membership to the society.

CAPE MAY COUNTY

Clarence W. Way, M.D., Reporter

A regular meeting of the *Medical Society of Cape May County* was held Tuesday, January 14, 1941, at 9 p.m., at the Ocean City Country Club, Somers Point, in honor of Watson B. Morris, M.D., President of The Medical Society of New Jersey. Forty one members and guests were present, as follows

Watson B. Morris	A. J. Friedland
LeRoy A. Wilkes	Ida Monasson
J. Calrisle Brown	Louis Bernheisel
Hilton Read	Marcia Smith
Robert Kilduff	George F. Dandois
Maurice Gordon	Frank Hughes
V. Earl Johnson	Samuel Hughes
Harry Subin	Samuel Gidding
Robert Dunham	John Townsend
Furmin Covington	Mrs. John Townsend
Joseph McCracken	B. H. Timberlake
Perry Frank	John Irvin
Edward Leonard	W. H. Hudson
Aldrich Crowe	Clarence W. Way
Thomas Petinga	James Taylor
Harold Davidson	Jules Cooper
Joseph J. Harty	Allen Corson
Alex Stuart	Herschel Pettit
Willets P. Haines	Stanley McGraton
Leland S. Madden	H. Rieck
Maurice Cohen	

An address of welcome was given by Dr. Aldrich C. Crowe, President of the Medical Society of Cape May County.

Dr. LeRoy A. Wilkes, Executive Officer of The Medical Society of New Jersey, spoke of the need of considering the business and social relations of the Medical Society, as well as its scientific service.

The honor guest of the evening, President Watson B. Morris, spoke on the work of the State Society during the present year and the opportunities for its future expansion.

SCIENTIFIC

A series of surgical cases had been arranged by Dr. David B. Allman; but on account of his sickness, his assistant, Dr. Harry Subin, presided during the presentation of the cases by Drs. Gordon, McCracken, and Covington, of the Atlantic City Hospital Staff. Dr. Robert Kilduffe illustrated the pathological aspects of the cases by means of lantern slides.

PERSONAL NOTES

Dr. John H. Whiticar, Ocean City, has been elected a Trustee of Temple University, Philadelphia, Pa.

Dr. Warren D. Robbins, Cape May City, has been appointed County Physician in the place of Dr. Millard Cryder, resigned.

Dr. Samuel S. Gidding, Wildwood, has been on active duty in the Navy at Quantico, Va., and left for three years' service January 24, 1941.

The members of the Cape May County Medical Society will meet as the guests of the Atlantic County Medical Society, February 14, and no meeting will be held in February.

Lt.-Col. E. S. Liuthicum, Trenton, will speak on "Medical Military Medicine and Outlines of Field Medical Service".

Dr. Edward S. Jennings, Cape May Court House, has resigned as a member of our Medical Society. He has joined the Army Medical Corps and been ordered to Indian Town Gap, Pa., as a specialist in eye, ear, nose and throat at the Cantonment Hospital.

ESSEX COUNTY

Paul H. Hosp, M.D., Reporter

The regular monthly meeting of the *Essex County Medical Society* was held in the Academy of Medicine, Thursday, January 9th, 1941. The meeting was called to order promptly at nine p.m. by Dr. Harry Comando, President.

SCIENTIFIC

Brigadier General Shelley Marietta, Assistant Surgeon-General, U. S. Army, Commanding Officer, Walter Reed Hospital, addressed the society on the topic, "Medical Preparedness for a Military Emergency".

MEMBERSHIP

Dr. Eugene Andermann was admitted to associate membership.

CARE OF PREMATURES

Recommendations for the care of premature babies were formulated by the Child Welfare Committee of the society in coöperation with the following organizations:

Child Health Committee of The Medical Society of New Jersey

Maternal Welfare Committee of The Medical Society of New Jersey

Maternal Welfare Committee of the Essex County Medical Society

Hospitals Committee of the Essex County Medical Society.

Arrangements will be made to publish this report in The Journal.

GLOUCESTER COUNTY

C. A. Bowersox, M.D., Reporter

The monthly meeting of the *Gloucester County Medical Society* was held at the Woodbury Country Club on January 16, 1941, with the President, Dr. Henry B. Diverty, presiding.

PUBLIC RELATIONS

Dr. Louis K. Collins, Chairman of Public Relations, requested that more speakers volunteer for various assignments throughout the county.

MEDICAL PREPAREDNESS

Dr. William Pedrick, Chairman of Medical Preparedness, reviewed many aspects of the problems in relation to medical preparedness in the county. Dr. R. D. Zapf also related some of his problems as a member of Draft Board Number One. He stated that one of his board had resigned and that four members should be required instead of the usual three.

Dr. Pedrick then reviewed some of the problems of taking care of the civilian population in the county in case of immediate invasion. He desired a list of the number of physicians who would respond to calls in such an event, and those who would stay at home for the same service. Places to locate and house the civilian casualties must be itemized. Coöperation of the local Red Cross, the State Police, and other local groups would be necessary.

Dr. Diverty then authorized Dr. Pedrick to appoint doctors in their various localities to perform these duties.

SCIENTIFIC

Dr. J. Harris Underwood then presented a very interesting talk and slide on the subject of obstetrical measurements of the pelvis, and their various complications.

After a few reels of motion pictures by Dr. C. A. Bowersox, the meeting adjourned at 11 p. m.

MIDDLESEX COUNTY

Cyril I. Hutner, M.D., Reporter

The regular meeting of the *Middlesex County Medical Society* was held at the Roosevelt Hospital, Metuchen, N. J., Wednesday, January 15, 1941, with the new President, Dr. R. J. Faulkingham, presiding.

MEMBERSHIP

Dr. Padie Richlin, New Brunswick, was elected to associate membership.

SCIENTIFIC

The paper of the evening, "Sulfathiazole—Its Adaptation in Urology", was presented by Dr. Robert L. McKiernan of New Brunswick. Dr. Harry Van Dyke, head of Pharmacology Research at Squibb's Institute for Medical Research, discussed the monograph. He stated that with this drug, a remarkably low dosage gives striking results, which shows that the organism is highly susceptible and further that the high concentration of the drug in the urine permits for adequate local action.

MEDICAL SERVICE ADMINISTRATION

Dr. Norman M. Scott of the Medical Society of New Jersey described the plan of *Medical Service Administration*, and asked the members of the County Medical Society to coöperate by signing up as participating physicians. The ultimate objective is to maintain a medical service agency operated and controlled by the medical profession which will be prepared to operate any plan which may come into this State.

On motion of Dr. F. M. Hoffman a committee was appointed to study the plan and report at the next meeting, and have the membership notified that the plan will be discussed. The motion also requested that literature pertaining to the plan be mailed to every member. Drs. F. M. Hoffman, Edward F. Klein and Joseph Mork were appointed on a committee to carry out the motion.

POST-GRADUATE

The Post-Graduate Course Committee suggested that the County Society pay for the course, and the members to decide by a poll the subjects that are to be given. The suggestion was adopted.

INDUCTION BOARD

A communication from Dr. Charles H. Schlichter was read advising the County Society about the establishment of a permanent Induction Board at Fort Dix, with openings for men in various specialties.

LOAN VOLUME

A two-volume book entitled "Study of American Medicine" is on file at our Executive Office, 105 Carroll Place, New Brunswick, and is available to any member of the County Society for a period of two weeks. A card system will be installed to enable Miss Kidd to keep tabs on who has the book.

After adjournment, refreshments were then served in the cafeteria of the hospital.

MONMOUTH COUNTY

Murray Woronoff, M.D., Reporter

The monthly meeting of *Monmouth County Medical Society* was held on Wednesday, December 18th, at The Berkeley-Carteret Hotel, Asbury Park. The President, Dr. D. F. Featherston, presided and fifty members of the society were present.

Dr. Stephen Richard Casagrande, of Belmar, N. J., was elected to membership.

SCIENTIFIC

Dr. Allen O. Whipple, Professor of Surgery, Columbia University, gave an illustrated talk on "Indications for Surgery of the Pancreas", which was followed by a general discussion.

OCEAN COUNTY

Raymond A. Taylor, M.D., Reporter

A meeting of the *Ocean County Medical Society* was held at the Paul Kimball Hospital in Lakewood on January 8th, 1941, with Dr. William E. Dodd, President, presiding.

The question of fees for examination of insane patients was discussed at length, and the matter was referred to a committee for further investigation.

SCIENTIFIC

A scientific program was given on "Medical Practice in Puerto Rico, Cuba and Mexico" by Dr. William E. Dodd and Dr. Carl H. Menge.

PASSAIC COUNTY

Irving Okin, M.D., Reporter

The regular meeting of the *Passaic County Medical Society* was held Thursday, January 9, 1941, at School No. 13, Paterson. President Frank W. Ash presided.

Dr. Howard F. Root, Physician at the New England Deaconess Hospital and Joslin Clinic, Boston, spoke of "The Medical Treatment of Foot Lesions in the Diabetic", and Dr. Theodore C. Pratt, surgeon at the same institutions, spoke of the surgical treatment.

MEMBERSHIP

The following physicians were elected to membership:

To active membership:

Walter I. Chapman, Jr., Hawthorne
Peter Conserva, Clifton
Meyer Mackler, Paterson
Morris A. Monaloy, Clifton

To associate membership:

Orlo H. Clark, Passaic
George Krieger, Passaic
Matthew J. Sheft, Passaic

Three applications for associate membership were read.

MEDICAL-DENTAL SERVICE BUREAU

The following doctors were elected to represent the Medical Society on the Board of Trustees of the Medical-Dental Service Bureau:

Leon E. De Yoe	Jacob Roemer
Norman M. Dingman	William Spickers
Sigurd W. Johnsen	Harry Wolfson

FOOD AND DRUG ACT

Dr. Yager then read a report on the Food, Drug, and Cosmetic Act of New Jersey, and its provision concerning physicians who dispense drugs. He pointed out that the law is very definite in stating that any drugs dispensed by a physician must be labelled with the patient's name and address, the doctor's name and address, and a serial number; and that all physicians must adhere to these regulations.

Dr. Ash announced that a letter would be sent to every member informing him of this law, because the State Board of Pharmacy is enforcing this provision.

CARDIAC AND CANCER COMMITTEES

The reports of the cardiac and cancer committees were read with reference to Dr. Lee's proposal that beds in the City Hospital be used for cardiac and cancer cases. After discussion, it was decided to appoint a committee to go into this problem more in detail and report back to the society.

WOMAN'S AUXILIARY

RELATION OF THE AUXILIARY TO THE INDIVIDUAL PHYSICIAN

By WILLIAM K. CAMPBELL, M.D., Long Branch, N. J.

Chairman, Advisory Committee to the Woman's Auxiliary to The Medical Society of

New Jersey

Abstract of an address before the Executive Board meeting, on January 13, 1941

I came today, at your invitation, to talk to you as Chairman of the Advisory Committee from the State Society to your organization. My subject is "The Relation of the Auxiliary to the Individual Physician". When I speak of "Your physician", I am speaking of the individual physician in your own family, your own relative, the titular head of your family group. Truly, you as wives or relatives of this individual physician wish to do anything you can to promote his well-being and progress; and by so doing you help all physicians.

Some three years ago I spoke to you on the rôle that laymen were playing in their encroachment on the physician's rightful place in the management of hospitals, clinics, and social welfare work. Physicians literally clapped their hands at all the wonderful charity organizations, the social groups, the nursing associations, the old age assistance laws, the unemployment insurance, the sickness and accident benefit associations, the various and illimitable alphabetic Federal agencies, and the host of other things designed to help people to forget or to evade their responsibilities and to be happy and care-free.

Where in all this was there provision for the physician and his family? Surely we are not to be bought and sold; and our pay, our hours, our acts are not to be prescribed by the lay managers of the hospitals, the clinics, and the political appointees of the various units of government. These laymen, with the lay personnel of these institutions, demand, and receive, adequate pay for their time,—they demand, and receive, regular hours and good working conditions. Then why should we contribute, freely and without pay, of our time, our knowledge, our experience?

Now, how can the Auxiliary serve to help the individual physician in this dilemma, and in so doing help each individual member of the Auxiliary toward a greater security and a greater satisfaction in your own home sphere? Each one is a partner in the medical unit that makes up your physician's professional, social, and financial family. Your counsel and co-operation is still in the aggregate an immense force for the good of the entire medical pro-

fession. A good wife, mother, or sweetheart can, in the indefinable way of a woman's mind, steer most men in the way they should go. They can relieve the tension and the worries of a busy medical household.

The women, by gathering all these small pushes in an organization like the Auxiliary, can conceivably make great oaks from little acorns grow. Do not think that the Auxiliary has to do great and glamorous things to be an impressive help to medicine; it is the little things that count.

Hobbies, I am convinced, tend to invigorate the mind, give pleasure to the possessor, and often to many others. Do not complain if your physician spends some of his time in recreation. It will repay both him and you in added congeniality, and in added strength of mind and body. Join him if you enjoy his hobby. If he has none, then get a hobby for yourself and enjoy the relief it gives from the regular routine of life.

To the women of the families of the medical men of New Jersey, I want to make a plea,—that you get solidly behind your officers, and lend them any help that you possibly can, if it be only by keeping up the County Auxiliaries by attending the meetings, and by unselfishly taking the county offices. Do the best that you can with these offices, answering promptly the communications of the State Auxiliary, keeping good and legible minutes of their meetings, making necessary reports to the State Auxiliary, and helping collect historical and personal items and transmitting them to the State Auxiliary. Surely there are thousands of little things that are to be done, and none can truthfully say, in any county, "Of what use is a County Auxiliary? We have nothing to do." There are so many, many thousands of things to do that no one who gives a tiny little bit of thought to the problem, can ask what is there to do. But she will be troubled by the thought of how best she can do some of the necessary things to help make the organization work.

Do not think of the great things, the wonderful things, that you would like to do; but do the little things, the things that make the world go round.

WOMAN'S AUXILIARY COMING EVENTS

ATLANTIC COUNTY

February 14, 1941, 8:45 p.m.

Play: "Consolation", farce with medical theme
Characters: Members of the Auxiliary

BERGEN COUNTY

February 11, 1941, 9:00 p.m.

Englewood Hospital, Englewood, N. J.
Red Cross Activity

BURLINGTON COUNTY

March 3, 1941, 2:00 p.m.

Moorestown Community House, Moorestown,
N. J.

Subject: Public Relations
Tea

ESSEX COUNTY

February 24, 1941, 2:00 p.m.

Academy of Medicine, Newark, N. J.
Movie: Laundry Association of N. J.
Subject: Charm and Beauty of Modern Textiles
Red Cross Activity
Tea

HUDSON COUNTY

March 3, 1941, 2:00 p.m.

Young Women's Christian Association, Jersey
City, N. J.

Speaker: Dr. George Kerdosha

Subject: Inoculations

Speaker: Dr. Julius Heilbrun

Subject: Children's Disorders

Reciprocity meeting

MIDDLESEX COUNTY

February 19, 1941, 8:30 p.m.

Residence: Mrs. Karl Rothschild, 149 Living-
ston Avenue, New Brunswick, N. J.

Musicale

SOMERSET COUNTY

March 13, 1941, 8:30 p.m.

Somerset Hospital, Somerville, N. J.

Speaker: Dr. Joseph Stokes

Subject: Pediatrics

LEGISLATION

By MRS. ALVAH W. BICKNER, Chairman of Legislation

Never before in the history of the Auxiliary has legislation been of such great importance, and never before have we, the wives of doctors, had such a great need and opportunity to help the profession.

Because of the activity of the Federal Government with preparedness plans, there has been a lull in national legislative activities. However, this does not mean that we should in any way lessen our interest or intense study of the situation. It is our good fortune that we have a little more time to inform our members with the attitude of the A. M. A. concerning this proposed legislation.

Earlier in the year I urged you to study the platform of the A. M. A. Ask some of your well-informed doctors to come and discuss it with you. Then, whenever the opportunity presents itself, either publicly or privately, put forth to the lay public the principles of the A. M. A. concerning socialized medicine.

The *Medical Service Administration*, which you heard about last year, has progressed very

nicely, and is now almost completely organized. It is hoped it will soon be put on trial in Essex and Union Counties. One great advantage in this plan is that 51 per cent of the doctors must agree to sign up before the plan may be established in a County. This allows for a wide free choice of physician.

The *Medical Preparedness Program* has received excellent cooperation in the State of New Jersey. We doctors' wives can help greatly by urging our husbands to answer and return the questionnaires sent them by the A. M. A.

Since the New Jersey State Legislature does not go into session until the middle of January, there is little activity at the present time. However, as the proposed legislation is forthcoming, I shall inform you.

May I plead with you to educate and inform yourselves of all legislative activities both Federal and State. Your opinion, if correctly expressed, will influence a legislator. It is your duty, as a doctor's helpmate, to further the interests of organized medicine.

EXECUTIVE BOARD MEETING

The mid-year meeting of the *Executive Board* of the Woman's Auxiliary to The Medical Society of New Jersey was held on January 13th, 1941, at the Trenton Country Club, Trenton, New Jersey. Forty-five members attended the business meeting in the morning, and there were sixty-six for luncheon.

At the business meeting the Committee Chairmen made their reports and Delegates to the Annual Meeting of the Woman's Auxiliary to the American Medical Association were chosen, as follows:

<i>Delegates</i>	<i>Alternates</i>
Mrs. G. E. McDonnell	Mrs. L. L. Glover
Mrs. A. J. Casselman	Mrs. H. A. Lippincott
Mrs. H. H. V. Hubbard	Mrs. F. A. Kinch
Mrs. J. Irving Fort	Mrs. C. I. Ulmer

Mrs. F. B. Gilpin
Mrs. James H. Mason
Mrs. R. J. McDonald
Mrs. R. J. Faulkingham
Mrs. LeRoy Wilkes
Mrs. A. Goldstein
Mrs. W. C. Meineke
Mrs. A. G. Merendino
Mrs. W. C. V. Wells
Mrs. A. S. Harden
Mrs. Anthony Ambrose
Mrs. William Friele
Mrs. William C. Ivins was Chairman of Arrangements for the meeting and was assisted by Mrs. John L. Wikoff.

Following the luncheon the members were entertained by a soloist, Mrs. Millicent DuBois, who was accompanied by Mrs. Norman Hartman.

The speaker of the day was Dr. William K. Campbell, Long Branch, Chairman of the Advisory Committee on Woman's Auxiliary. His address is printed as the first article of this department.

COUNTY AUXILIARIES

Atlantic County

Reported by Mrs. Matthew Molitch, Publicity Chairman

The regular meeting of the *Woman's Auxiliary to the Atlantic County Medical Society* was held on Friday, January 10, 1941, with Mrs. Anthony G. Merendino, President, presiding, and twenty-seven members present.

A report was received from the Program Chairman, Mrs. Carl A. Surran.

Dr. Robert A. Kilduffe gave a review of the book "Not So Long Ago" or "Chronicle of Medicine and Drugs of Colonial Philadelphia", by Dr. Cecil K. Drinker.

A short musical program followed.

Bergen County

Mrs. J. Willis Demarest, Chairman of Publicity

The regular meeting of the *Woman's Auxiliary to the Bergen County Medical Society* was held January 14, 1941, at the Hackensack Hospital with Mrs. R. N. Berke presiding, and twenty-two members present. Mrs. G. E. McDonnell was a guest.

Mrs. Alvah Bickner, Public Relations Chairman, gave her report and asked for volunteers for her committee. Mrs. Berke urged the members to join the Widows and Orphans Society. Mrs. McDonnell asked the members to subscribe to the Bulletin.

The speaker of the evening was Mrs. Arthur F. Coca, who spoke on "Blood Groupings of Primitive People in the Far East".

The Auxiliary will sponsor a bridge party on April 22nd at the Hackensack Golf Club, the proceeds of which will go in the philanthropic fund.

Refreshments were served.

Camden County

Reported by Mrs. E. R. Hirst, Publicity Chairman

The regular meeting of the *Woman's Auxiliary to the Camden County Medical Society* was held on Tuesday, January 7th, 1941, at the home of Mrs. A.

H. Lippincott, 406 Cooper Street, Camden, N. J., with the President, Mrs. L. L. Glover, presiding, and thirty-two members and two guests present.

Routine reports were received from officers and chairmen.

Mrs. G. F. West announced the Annual Card Party, to be given on March 3, at The Walt Whitman Hotel, Camden, N. J., with a Fashion Show by Oppenheim Collins, of Philadelphia, Pa.

Mrs. O. R. Carlander reported progress on the program for the Public Relations Meeting on March 25. She also called attention to the radio program sponsored by the American Medical Association called "Doctors at Work" given on Wednesday evenings at 10:30 p.m.

The following Nominating Committee was named: Mrs. Joseph E. Roberts, Chairman; Mrs. Oram R. Kline, Mrs. George B. German, Mrs. H. Wesley Jack, Mrs. William J. Scruggs.

The President also announced the following meetings, to which the members of the Auxiliary are invited:

January 9—Public Health Forum, at the Bellevue Stratford Hotel, Philadelphia, Pa.

January 13—State Board Meeting at Trenton, N. J.

January 14—Philadelphia County Medical Auxiliary Councilor and Reciprocity Luncheon and Meeting.

March 10—Open Meeting of the State Medical Auxiliary Executive Board at Newark, N. J.

The guest speaker, Mrs. Homer C. Loh, of Crozier Theological Seminary, Chester, spoke on "The Present Condition of China".

Our guest of honor, Dr. Mabel G. Leshner, of Camden, N. J., who served as an American Medical Missionary in China, also spoke about China, and exhibited a collection of plates, wall hanging, vases, and linen drawn work, which were very beautiful and most interesting.

Meeting adjourned at 3:45 p.m., and tea was served.

Gloucester County

Reported by Mrs. Clarence A. Bowersox, Public Relations Chairman

The special meeting of the *Woman's Auxiliary to the Gloucester County Medical Society* was held Thursday evening, January 9th, at the home of Dr. and Mrs. Clarence A. Bowersox, of Woodbury, with about twenty-five members and their husbands present.

Dr. William Pedrick, of Glassboro, showed colored slide pictures of his recent Western, Canadian and Florida travels.

Dr. C. A. Bowersox showed his colored motion pictures on garden scenes.

The meeting was followed by a buffet supper.

Hudson County

Reported by Mrs. Sydney Chayes

The *Woman's Auxiliary to the Hudson County Medical Society* met Monday afternoon, January 6, 1941, in the parlors of the Young Women's Christian Association, 270 Fairmont Avenue, Jersey City, N. J., with Mrs. Arthur Largay, President, presiding. After a business session the ladies enjoyed a talk by Miss Margaret Byrnes of L. Bamberger & Company's Book Department, in which she reviewed about forty modern adult books.

Tea was served after the talk by Miss Byrnes, with Mrs. Andrew Ruoff, and Mrs. John Nevin as hostesses.

Preceding the regular meeting, the Entertainment Committee met at luncheon. Plans were completed for a Bridge, Tea, and Fashion Show at Hotel Pierre, New York City, on January 18, 1941.

BOOK REVIEWS

OFFICE UROLOGY, WITH A SECTION ON CYSTOSCOPY. By P. S. Pelouze. Pp. 766. Philadelphia, W. B. Saunders Company. 1940. \$10.00.

This work is above all practical. It is beautifully written and profusely illustrated, largely with a semi-diagrammatical form of illustration which brings out the point the author wishes to make much more clearly than a profusion of words.

The author has borrowed, and rightly so, from every available source, and the result justifies his methods. By limiting the scope of the work to office procedure and minor surgery, he has been able to go into great detail on the smaller, practical points which one encounters in every-day practice.

The chapter on gonorrhea gives the gist of the author's own ideas which he has so well expressed in other works; and while we may not always agree with him, we must respect the vastness of his experience and clarity of his thoughts. In the chapter on the sexual problem, he includes some valuable philosophy, along with the purely medical consideration.

This is a work which can be used with benefit by both the general practitioner and the specialist.

W. L. JAMES, M.D.

CLINICAL DIABETES MELLITUS AND HYPERINSULINISM. By Russell L. Wilder, M.D., Ph.D. Pp. 459. Philadelphia, W. B. Saunders Co. 1940. \$6.00.

This is a book which one would anticipate from an author with such a wealth of material as was available to him. The text reflects his thorough grounding in critical experimental physiology and its proper application to clinical medicine.

The first section gives a neat summary of the effect of the other endocrines on carbohydrate metabolism. The differential diagnosis and therapy are to the point. There is an ingenious nomogram

for calculating diets, as well as the usual food tables. The chapter on insulin administration is especially clear and complete, and protamin zinc insulin is thoroughly discussed.

Beginning with acidosis, the complications of diabetes and their treatment are well handled. No other text gives so much room to the various phases of hyperinsulinism. The text reads easily, and the references and illustrative cases are numerous. This book bids fair to find its place in the lasting group of literature on diabetes mellitus.

EVERETT O. BAUMAN.

APPLIED PHARMACOLOGY. By Hugh Allister McGuigan, Ph.D., M.D. Pp. 914. St. Louis, C. V. Mosby Co. 1940. \$9.00.

The author has attempted to present pharmacology in a useable form. The method of presentation is interesting and the scope of the book rather extensive. The section on cathartics is excellent and should be read with profit by every practitioner of medicine.

The part on chemotherapy of syphilis is misleading, as it apparently includes long discussions on heavy metal poisoning. The section on lead, thus misbranded, certainly deserves a better fate and a heading of its own.

The general arrangement of the book and the printing are commendable.

M. OPENCHOWSKI.

THE VIRUS: LIFE'S ENEMY. By Kenneth M. Smith. Pp. 176. N. Y., Macmillan; Cambridge, England, Oxford University Press. 1940. \$2.00.

The subject of virus and the diseases they cause is simply and clearly told. The book is a welcome addition to the Library of Modern Science, and will

be profitably read by anyone, even the members of the medical profession.

MODERN DERMATOLOGY AND SYPHILOLOGY. By S. William Becker and Maximilian E. Obermayer. Pp. 871. Philadelphia, J. B. Lippincott Co. 1940. \$12.00.

This is one of the newest textbooks in the field of dermatology and syphilology. It is well printed on excellent paper, and contains thirty-two colored illustrations, as well as many black and white pictures. It is easy to refer to individual diseases, which are grouped according to common etiology. Each chapter has a complete bibliography and there is special information relating to each group of diseases dealing with the newest type of therapy, and excluding some of the older types.

There is an excellent treatment chart in the section on syphilology which was worked out according to the technic of the University of Chicago clinics.

This is an exceptionally good volume for use both as a textbook and a reference book for those in the field of dermatology and syphilology.

BART M. JAMES.

PRACTICE OF MEDICINE. By Jonathan Campbell Meakins. 3d ed. Pp. 1430. St. Louis, C. V. Mosby Company. 1940. \$10.00.

The publishers of this new edition have reduced eye-strain by printing it on green-tinged, low-gloss paper.

This excellent text has been revised to include the newer developments of chemotherapy, and the rôle of vitamins. There is a comprehensive index, and excellent illustrations of which forty-eight are in color. All the commendable features of previous editions have been retained.

PUBLIC HEALTH ADMINISTRATION IN THE UNITED STATES. By Wilson G. Smillie, M.D. 2d ed. Pp. 553. New York, The Macmillan Co. 1941. \$3.75.

Professor Smillie has emphasized again the growing stature of Public Health as a science, inasmuch as a volume of this size can be written upon the administrative side alone.

The chapter on public health nursing is an innovation. The nurse in public health carries out so many different duties, none of which is strictly nursing, that it would seem to be illogical to summarize them all under the heading of public health nursing. In such a set-up as envisaged by Professor Smillie, one can imagine considerable embarrassment for the professional division head whose orders might be subject to the criticism of a nursing superior.

The book points out that there is no mystery in disease control, and that success depends upon common and easily understood principles. The part taken by the modern public health laboratory in public health administration is well covered.

Of necessary importance in public health admin-

istration is the part played and to be played by the Federal Government. The chapter on "Health Administration in the Federal Government" is a timely and useful addition to the book.

Professor Smillie has written an extremely well-informed volume upon the newer public health administration. The only thing one seems to miss in such a standard work is a sufficient number of illustrations and diagrams in order to make more clear some of the essential facts and theories of public health procedure.

CHARLES V. CRASTER, M.D.

MORE YEARS FOR THE ASKING. By Peter J. Steincrohn, M.D. Pp. 218. New York, D. Appleton-Century Co. 1940. \$2.00.

Dr. Thomas Parran, Surgeon General of the U. S. Public Health Service, says, "It would be possible to add ten years to the average life span of people living in the United States if we made full use of the scientific knowledge now available." "More years are yours for the asking," says Dr. Steincrohn, "if you will consult your doctor early and often." This excellent little book is written primarily for the laity, but this reviewer recommends the chapter "Learn to Be Lazy", especially to all medical men. More Years for the Asking is a "must" book for every doctor's waiting room.

EDWARD M. FINESILVER.

ARTHRITIS AND ALLIED CONDITIONS. By Bernard I. Comroe, M.D. Pp. 752. Philadelphia, Lea & Febiger. 1940. \$8.50.

In this book the important data relating to arthritis is carefully assembled and clearly presented. The unique plan of outline inserts emphatically summarizing the material of each chapter is useful for quick reference.

Nearly one-half of the space is devoted to rheumatoid arthritis. The author designates that there is no effective single form of treatment for this disease and that although one may decide to remove foci of infection, give vaccine, administer gold salts, etc., during the entire period a program of rest, physical therapy, exercises and adequate caloric and vitamin intake must be maintained.

A wise attitude toward gold therapy is adopted. The use of this toxic drug is recommended only after more conservative measures have been tried and not then if there are contraindications and not unless frequent tests for toxicity are carried out.

Toward the end of the book there are chapters on special subjects such as "Painful Shoulder", "Painful Feet", "Backache" and "Sciatica" which should not be overlooked.

This compact volume is especially valuable to the practicing physician because of information regarding the diagnosis, prognosis and treatment of arthritis, and to the investigator because of the comprehensive survey of the literature and extensive bibliography.

JOHN W. GRAY, M.D.

DISEASES OF THE DIGESTIVE SYSTEM. Edited by Sidney A. Portis, M.D. Pp. 952. Philadelphia, Lea & Febiger. 1941. \$10.00.

This book will be the definitive single volume on digestive diseases. The fifty contributors are authorities in the field of gastroenterology. Each chapter could have been a book in itself. However, the editor wisely demanded condensation, and as a result the volume contains only the salient features of each subject discussed. The general practitioner now has available one volume to which he may refer for a concise, accurate coverage of any problem of digestive diseases. The publishers are to be complimented on keeping the price of the book within the reach of all doctors. The paper, binding, illustrations and printing are of excellent quality and make for easy reading. This book should be on the shelf of every practitioner interested surgically or medically in gastro-intestinal disease. It will save the purchase of several single volumes.

MANFRED KRAEMER, M.D.

FOREIGN BODIES LEFT IN THE ABDOMEN. By Harry Sturgeon Crossen, M.D., and David Frederick Crossen, M.D. Pp. 762. St. Louis, C. V. Mosby Co. 1941. \$10.00.

This is a fine book on a most unusual subject which it covers in great detail. Various technics and methods of controlling instrument and sponge counts are discussed at length. The section relating to the legal aspects of the problem is illuminating and contains the abstracts of the various cases which have come to court. All operating room supervisors, members of surgical departments and the medical defense committees of medical societies will find this a most profitable volume.

OBSTETRICS IN GENERAL PRACTICE. By J. P. Greenhill, M.D. Pp. 448. Chicago, The Yearbook Publishers. 1940. \$3.50.

This practical handbook is intended primarily for the general practitioner as a handy reference. The text is abundantly illustrated. There are fifty-eight diagnostic and differential tables, also the classifications recently adopted by the American Committee of Maternal Health. The chapters on ante partum

care and conduct of the three stages of labor are fundamental and sound. The chapter on infiltration anesthesia carries much authority because of the author's extensive experience with it. Its technic can easily be learned from a study of the text and should be more widely used, especially during this season when respiratory infections are prevalent and an inhalation anesthetic may be undesirable.

This book should find a useful place in the library of every doctor practicing obstetrics.

ALFRED MEURLIN, M.D.

YEAR BOOK OF PUBLIC HEALTH. Edited by J. C. Geiger, M.D. Pp. 560. Chicago, Yearbook Publishers. 1940. \$3.00.

This book is the same type as the long-established year books heretofore devoted to clinical medicine. This is the first to appear in the field of public health and is a very real contribution.

It presents in a concise form contributions through the year on public health. From a medical standpoint, today when physicians are taking a larger interest in preventive medicine, this is a book which can be particularly recommended to those who feel called upon to have an opinion even though not actively practicing in this field.

JULIUS LEVY, M.D.

EMPEROR'S ITCH; THE LEGEND CONCERNING NAPOLEON'S AFFLICTION WITH SCABIES. By Reuben Friedman. Pp. 82. N. Y., Froben Press. 1940. \$1.50.

This book contains an intriguing theory as to the cause of some of Napoleon's idiosyncrasies, interestingly and amusingly told.

HANDBOOK OF HEARING AIDS. By A. F. Niemoeller. Pp. 156. N. Y., Harvest House. 1940. \$3.00.

COMPLETE GUIDE FOR THE DEAFENED. By A. F. Niemoeller. Pp. 256. N. Y., Harvest House. 1940. \$3.00.

These two books have available information which might require some research to obtain otherwise, and which is of value in instruction of and in securing proper aids for, the hard of hearing person.

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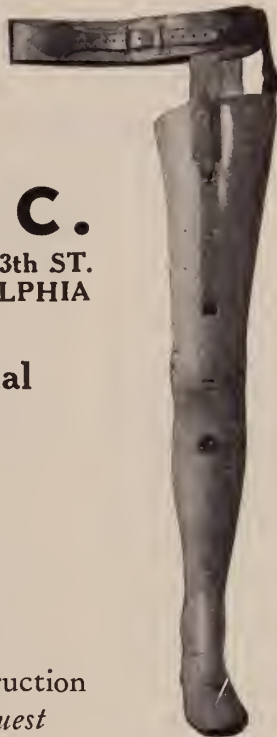
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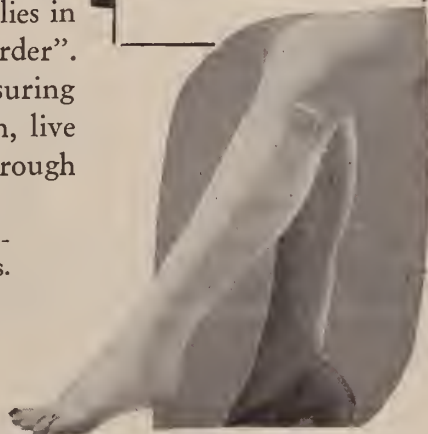
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BELMAR	William T. Lins, 1500 F St., cor. 15th Ave.	Belmar 559
BERNARDSVILLE ..	Hemmendinger Pharmacy, 12 Mine Brook Rd.	Bernardsville 78
BLOOMFIELD	Nicholas G. Burgess, 50 Broad St.	Bloomfield 2-1006
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HARRISON	Squier's Pharmacy, 234 Harrison Ave.	Harrison 6-2127
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NEW BRUNSWICK ..	Hoagland's Drug Store, 365 George St.	New Brunswick 49
PLAINFIELD	The Richmond Pharmacy, 209 Richmond St.	PLainfield 6-5312
RED BANK	The H. T. Young Pharmacy, 85 Broad St.	Red Bank 164
RUTHERFORD	Bergen Pharmacal Co., Park & Erle Aves.	RUTherford 2-0034
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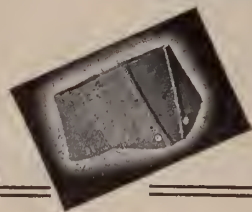
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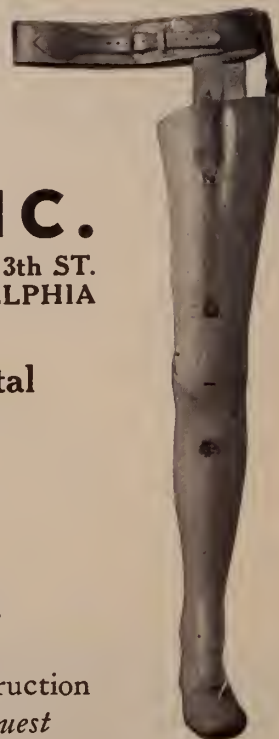
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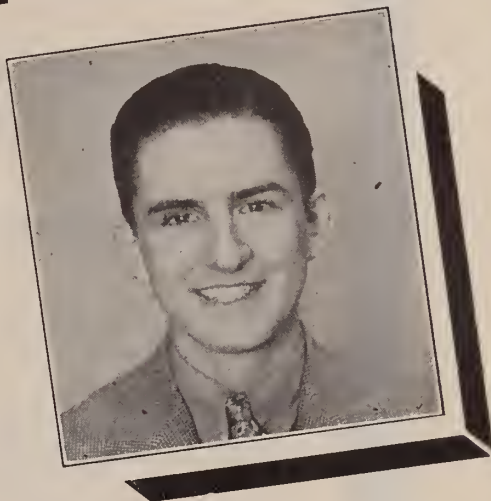
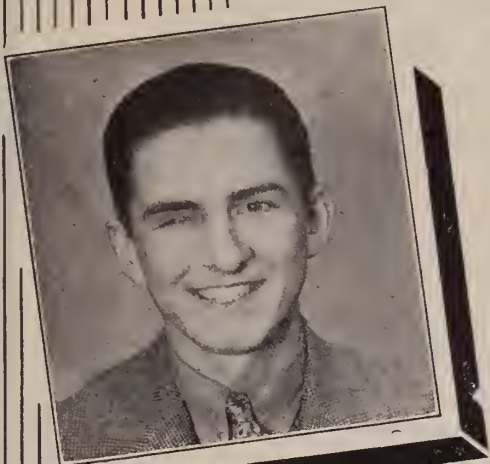
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Potass. bromid	9.23	160.00	13.90
Potass. iodid	1.10	4.80	1.36
Sodium sulphate	None	None	None
Sod. metaborate	Trace	None	Trace
Sodium nitrate	Trace	Trace	Trace
Sodium nitrite	Trace	Trace	Trace
Sodium bicarb.	2,213.78	424.71	1,331.15
Calcium bicarb.	1,829.14	3,380.84	2,519.74
Barium bicarb.	16.67	25.65	25.00
Strontium bicarb.	Trace	Trace	Trace
Ferrous bicarb.	9.94	40.07	5.86
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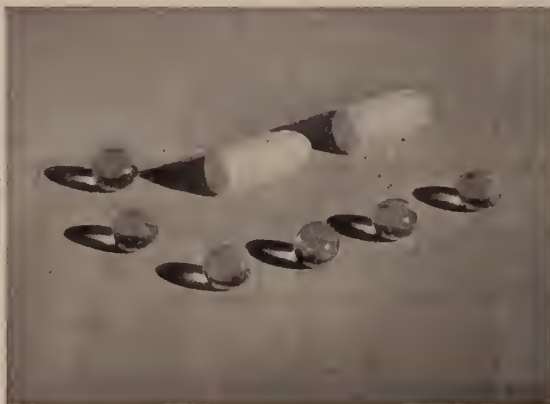
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¹ Sevringhaus, E. L., and Evans, J. S.: *Am. J. M. Sc.* 178:638, Nov. 1929.

² Novak, Emil: *Surg. Gynec. & Obst.* 70:124, Jan. 1940.

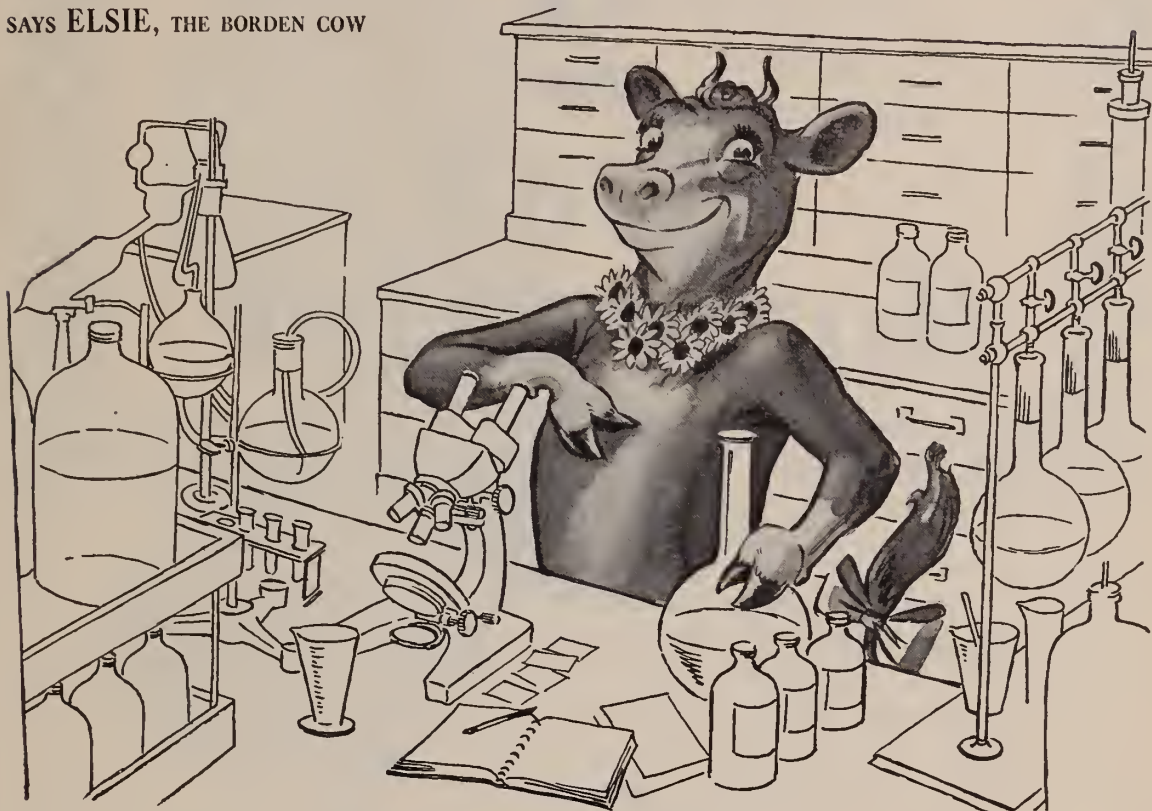
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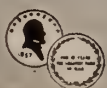
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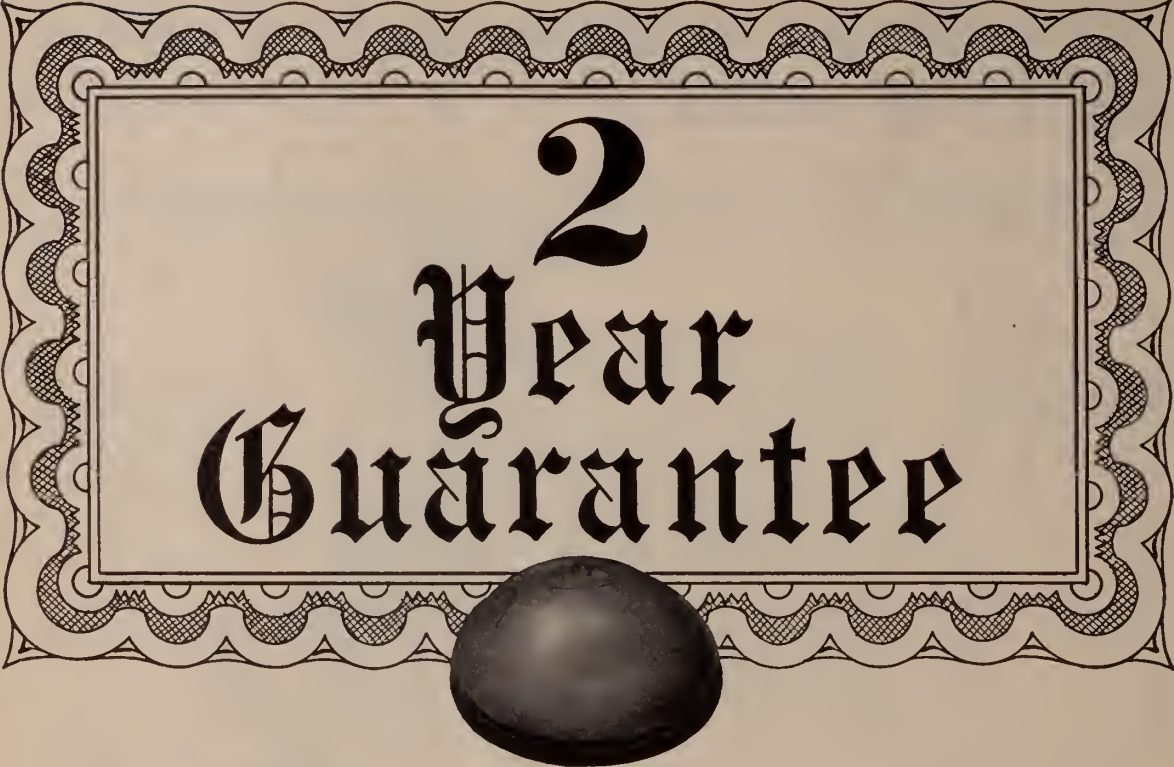
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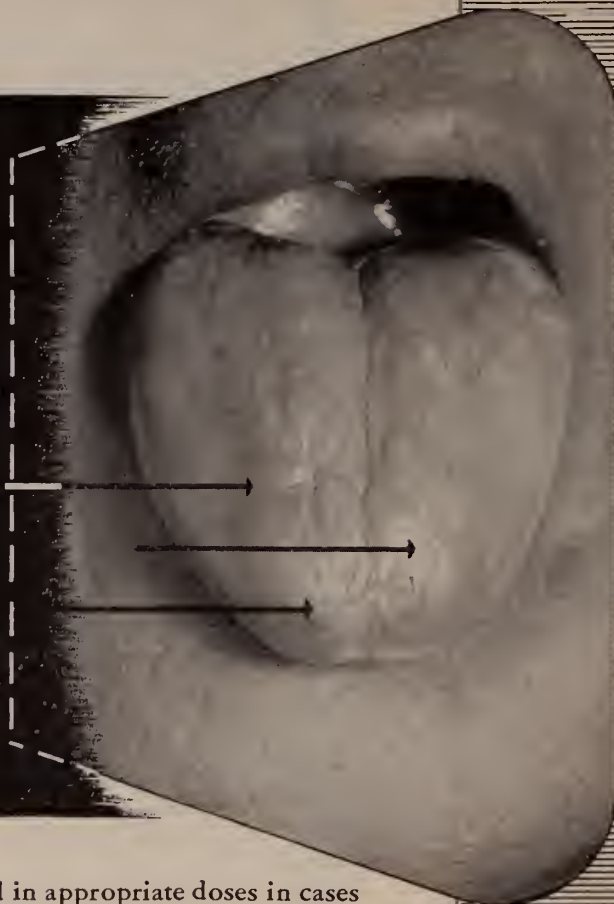
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The administration of nicotinic acid in appropriate doses in cases of pellagra leads to the clearing of alimentary lesions and symptoms, including the typical glossitis, to the disappearance of dermal lesions characteristic of the disease, and to profound improvement in the mental symptoms when the latter are the result of inadequate intake of nicotinic acid.

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Nicotinic acid is pyridine-3-carboxylic acid—C₆H₅O₂N. It is recognized as a specific in the treatment of the disease of dogs known as blacktongue and in the treatment of human pellagra.



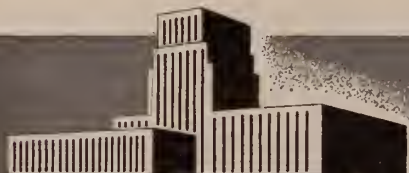
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ADVANCES IN CANNING TECHNOLOGY

III. Modern Heat Processes for Canned Foods

● "This new method of preserving . . . proceeds from the simple principle of applying heat . . . in a due degree to the several substances after having deprived them as much as possible of all contact with the external air." (1)

In this concise manner, Nicholas Appert, discoverer of canning, summed up the salient features of his procedure. Appert's method consisted of sealing prepared foods in wide mouth glass bottles with corks and processing the sealed bottles in a bath of boiling water. The first English edition of his book (1) describes Appert's procedures for some fifty products. While the times of his heat processes varied between products, the temperatures of the processes were uniformly that of boiling water.

After the spread of commercial canning to America, early canners soon found that spoilage frequently resulted when Appert's heat processes were employed. Increasing the time of process at 212°F. alleviated but did not entirely control this difficulty. As recently described (2a), attempts were next made to increase the temperature of process, either by the addition of soluble salts to raise the boiling point of water, or by the use of the autoclave which permitted processing under steam pressure at temperatures above 212°F. About 1874, an improved type of autoclave was invented in the United States and gradually came into general use for certain types of products. While this device reduced spoilage considerably, losses still occasionally resulted due to inadequate heat processing.

Between 1895 and 1900, the new-born science of bacteriology was first applied to

the canning industry. These early discoveries are well described elsewhere (2, 3); important among the findings was the fact that for products most favorable for growth of spoilage organisms, there is a minimum time of process which must be applied at a given temperature for a given can size, if preservation of the food is to be assured. The need for standardization of heat processes was thus clearly indicated.

During the past twenty years, the heat processing of canned foods has truly been placed on a sound scientific basis (4, 2b). The natural acidity of the food now determines the process temperature to be used. Foods with pH values below 4.5 may be safely processed at 212°F. or below; the "non-acid" foods with pH values above 4.5 require elevated process temperatures, 240°F. being the temperature most widely employed.

Today, adequate heat processes for non-acid foods are mathematically calculated using data which take into consideration all factors influencing the sterilizing value of a process. Processes thus calculated are thoroughly tested before being incorporated into bulletins of recommended processes which modern canners follow (5).

This establishment of adequate heat processes—particularly for the non-acid foods—is one of the greatest advances in canning technology made in the history of the industry. Today, it is apparent that the success of many of Appert's heat processes was due to fortuitous circumstances. The modern consumer, however, has the assurance that commercially canned foods are among the most wholesome foods reaching his table.

AMERICAN CAN COMPANY

230 Park Avenue, New York, N. Y.

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We want to make this series valuable to you, so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned-foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles. This is the sixty-ninth in a series which summarizes, for your convenience, the conclusions about canned foods reached by authorities in nutritional research.



The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Council on Foods of the American Medical Association.

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Nestled in the hills of picturesque Rockland County, N. Y., Lederle's 70 buildings and 200 acres resemble the campus of a typical American university. Broad lawns, elms, no smoke, no noise—a scene of spaciousness and peace!

In fact, many of the hundreds of visitors who tour the laboratories each year have remarked on its academic atmosphere. This is not a strange impression when one reviews the scholarly activities of the physicians, bacteriologists, chemists, pharmacologists, immunologists and veterinarians who make up a large percentage of the roster of 1100 employees.

Behind the scenes we find a large two-grade school (organized by employees who wanted to orient themselves and qualify for advancement), seminars of technicians and scientific committees.

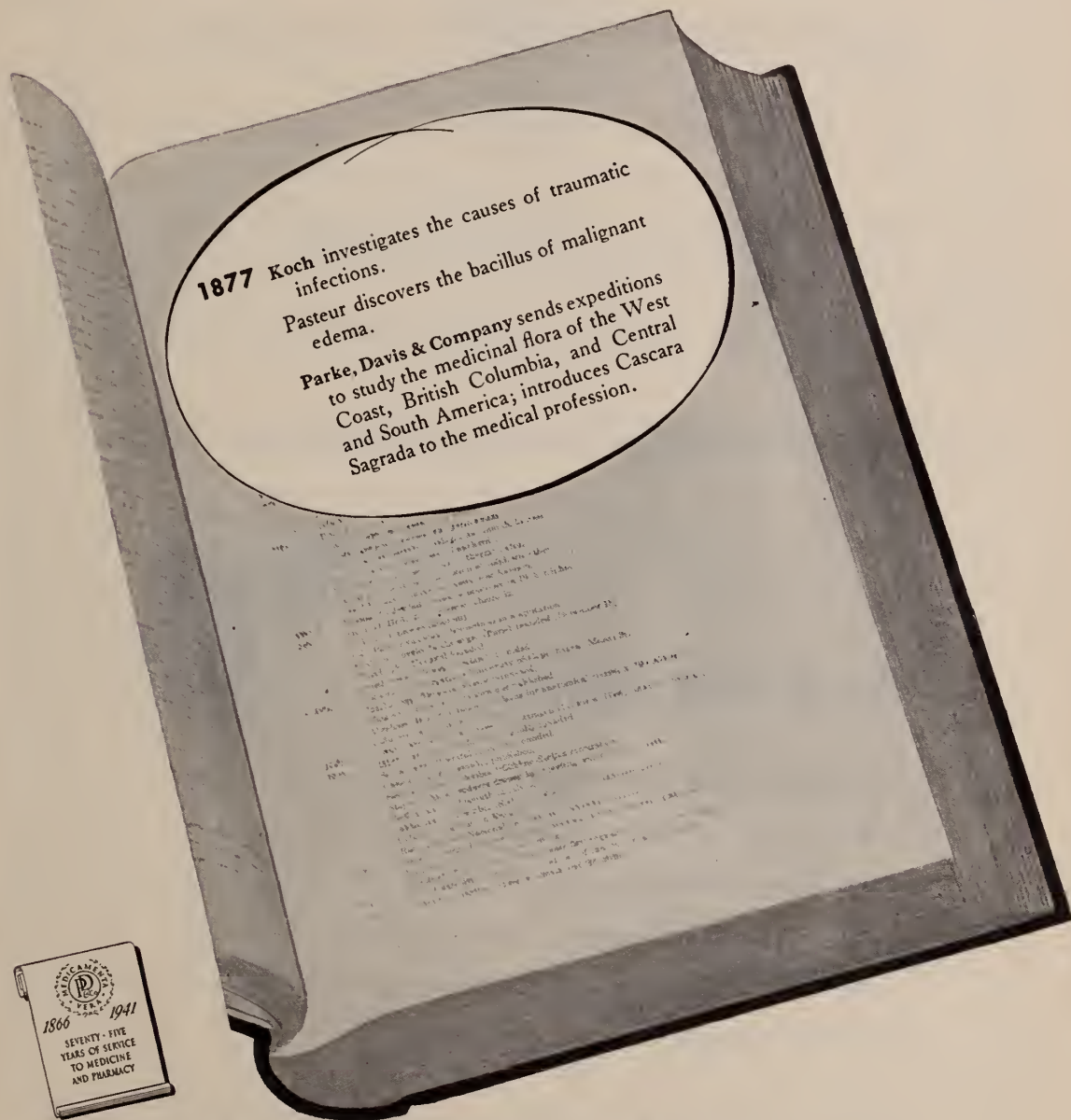
Finally, as Lederle is presumably the world's largest producer of "biologicals", we find here, naturally enough, the largest commercial group of scientific pioneers dedicated to the art of perfecting sera, anti-toxins and vaccines and filling whole buildings reserved exclusively for research. Ten universities and numerous clinics cooperate on Lederle subventions.



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THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

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EXECUTIVE ASSISTANT—NORMAN M. SCOTT, M.D.

Each member of the State Society is entitled to receive a copy of THE JOURNAL every month.

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EDITORIAL

Medical Preparedness and Home Defense

Many recall the confusion and hysterical haste which were conspicuous features of the medical preparations of the last war. At that time practically no medical preparations were made until after we were actually engaged in the conflict.

In marked contrast to this, we now find active steps are being taken to adequately prepare the medical personnel so as to avoid any such condition.

The real purpose of the questionnaire which was mailed to every member of Organized Medicine was to facilitate the work of classifying and cataloging the profession so that there will be "Far fewer round pegs in square holes" than in the last war.

Out of the 115,000 replies to the questionnaire, 50,000 of those were transferred to punch cards that will show the number needed for any particular service by running them through a machine.

Dr. Irvin Abell, Chairman of the National Committee on Medical Preparedness, in a report to the American College of Surgeons held at Chicago last October, stated that it would be necessary to have available 7500 physicians for each million men under arms.

These men will be chosen according to the qualifications shown on the questionnaires which should be on file at the offices of The American Medical Association in Chicago. They will be selected to fit specific duties, and will be accorded rank commensurate with the assignment.

Opportunities for advancement will undoubtedly be made for those who take advantage of the courses offered in the medical specialties, particularly those related to military medicine, such as traumatic surgery and aviation.

The latter is of great importance, because it is necessary to have a large number of doctors trained in this field, as the selection of the men who are to pilot the aircraft is more necessary than the number of planes to be built.

Qualified men in large numbers will be needed to continue and even intensify their efforts along the lines of research. As Surgeon-General Parran has pointed out, it may be that the nation which first learns how to control influenza may by this knowledge tip the scale towards victory in the wars ahead.

Medical Preparedness is a vital phase of total preparedness for possible war; and the

medical profession is laying plans so that if need be "We will be ready". The American Medical Association, who advocated it, should be commended for its anticipation and formulation of the plans of action adopted by them.

The membership at large deserves much

praise for its prompt action when called to act, for the parent organization would not have functioned so smoothly if that coöperation had not been forthcoming.

WATSON B. MORRIS, M.D.,
President.

The Doctor As a Citizen

Physicians, it is sometimes charged, show scant interest in the cultural life of the community. Time was when the doctor, like the clergyman or the teacher, was a civic leader whose opinions on art, politics, or philosophy were eagerly sought. In reviewing the history of The Medical Society of New Jersey, one notes, for example, that the eighteenth century physician was often a mayor, an alderman, or a congressman; and always an active, public-spirited citizen.

Today's complaint is that doctors are too narrow. "Whenever M.D.'s get together," runs one grievance, "they talk of nothing but medicine." We do not know how true that is, but we do know that, if physicians lose touch with wide civic problems, it will threaten their prestige, and ultimately lead to their classification as plodding technicians.

Two possible remedies may be suggested:

1. Let medical societies,—county or private,—more often listen to non-medical speakers on community questions.

2. Let medical organizations more actively participate in civic affairs.

Thus, the Society of Surgeons last month, under the leadership of Dr. Sprague, invited Eric Sevareid to discuss the current European situation. Here was a thought-provoking, non-medical talk topping off a full day of surgical demonstrations and scientific papers. It set up a healthy ferment of fresh discussion, and served notice that we doctors are citizens with a tremendous stake in the community. We demonstrated an intelligent interest in the body-politic as well as in the body-biologic.

Your Public Relations Committee furnishes

medical speakers to non-medical groups. We doctors address bankers and barbers, lawyers and laymen, teachers and typists; and yet we seldom ask non-medical speakers to tell *us* anything about non-medical subjects. Why not?

Participation, furthermore, should be active as well as passive. It is good to see the Academy of Medicine of Northern New Jersey co-sponsor the Town Hall—and not just the Lahey meeting, but also the forums at which such varied authorities as Erika Mann, Eve Curie, and Clifton Fadiman spoke. The Academy, one of a select list of participating civic organizations, announced in effect that doctors are citizens, too. In varying scale, this kind of participation is open to any medical organization. Any county society or private medical club can co-sponsor a civic activity to its own great advantage as well as that of the community.

To win public admiration for our scientific skills is not enough;—we must also win respect *as citizens*. If we ignore the welfare and cultural activities of the community, we brand ourselves as civically irresponsible medical mechanics. By plunging into the intellectual life of the community, we can earn a solid place in the minds and hearts of our fellow-citizens.

A century ago, a passer-by tipped his hat as he greeted the doctor in the street. We do not ask for such outward symbols today. But we do want the affection and respect which that hat-tipping implied; and we will get it if we earn it.

CHARLES M. ROBBINS, M.D.,
Chairman, Public Relations Committee.

Practical Industrial Hygiene

On January 9th, 1941, the Somerset County Medical Society visited the Calco Chemical Company plant in Bound Brook. This was a step in the right direction.

The program included:

- a. Plant inspection.
- b. A brief discussion of certain phases of industrial hygiene and health.
- c. Inspection of the new medical department.
- d. Dinner, which was served at the company cafeteria.

The safeguarding of the health of the industrial worker is among the foremost defenses of this country at all times, but especially so when America is to become "The Arsenal of Democracy". Every hazard of industry cannot be entirely eliminated, and physicians must be made aware of these hazards. They *must* know how these effects are made manifest in the worker. Then, and only then, can a physician successfully treat such patients.

The visitation to the Calco Company demonstrated not only *how* and to what *extent* these hazards are controlled, but also how their *effects* are diagnosed and treated. The business efficiency and economy with which the patient is brought promptly under the doctor's care was demonstrated, and also how the patient is placed *entirely* in the competent professional charge of the physician. The equipment and supplies which are provided are entirely adequate, and are conveniently arranged for immediate use.

Here was a practical demonstration of medical facilities and personnel organized for *service*, and meeting the highest professional standards.

Benefits accruing from such visitations go to both the physicians and their patients.

LEROY A. WILKES, M.D.,
Executive Officer.

Adequate Physical Examinations

A complete Physical Examination, with x-ray and other diagnostic aids, is the basis of case-finding and good medical practice. A thorough physical examination is essential for early diagnosis. A real opportunity to learn its up-to-date methods is offered in the Post-Graduate Course, arranged and announced by The Medical Society of New Jersey, through its Committees on Tuberculosis and Post-Graduate Education. This course will be held

in The Hudson County Tuberculosis Hospital, 100 Clifton Place, Jersey City, on Monday and Friday afternoons during the month of April. The fee is five dollars (\$5.00) for the entire course. See page 143 for the program and staff.

Enroll early!

Application blanks are available through your County Medical Society Secretary, or the Executive Offices in Trenton.

L. A. W.

The Medical Service Administration and the Physician

The Medical Service Administration is the reply of the physicians of New Jersey to the charge made by the Federal Government that physicians are not supplying a considerable proportion of people with the medical services which they need. Many persons in New Jersey are not able to finance the costs of catastrophic illness out of their current earnings.

It will be a great source of inspiration and encouragement to the family doctor as well as the specialist to know that the money is on hand to pay for the services that he delivers to the patient.

The law governing the operation of the Medical Service Administration carries a wise provision that at least fifty-one per cent of the

physicians of any county must agree to become participating physicians of Medical Service Administration before any medical plan may be operated in that county by the Administration. The object of this requirement is to assure for practical purposes the free choice of physician to the patient and a united effort by the profession.

We value an item of progress by the amount of effort which we have expended in securing it. A physician will set a high value upon a plan which he himself has promoted. The success of the Medical Service Administration will depend on the interest and effort with which the physicians support it.

Distributing Medical Services

In a public speech given on December 9, 1936, entitled "Industry Must Speak Constructively", Ernest T. Weir, Chairman, the National Steel Corporation, said:

"Industry fills a double function. It is a *maker* of goods. It also is an *exchange* through which the worker trades the products of his specialized skill for the other products that he needs. There is hardly a person who would have anything but praise for industry's performance of the first function—that of making goods. Now it is demanded that industrial leaders improve the *second function*—that they

develop industry so that its efficiency as an *exchange* will equal its efficiency as a *maker* of goods, and thereby improve industry's *social* function as they have already improved its *technological* function."

This statement proved to be prophetic. Organized Medicine must speak constructively. It too fulfills a double function in providing, and distributing medical service. The effective *distribution* of its service lags far behind its efficient *professional* knowledge and skill.

L. A. W.

The Health Examination and Early Diagnosis

The age of realism seems to have returned, and this should in part at least have a wholesome effect upon many professional, educational, and social programs and procedures. Efforts and funds must now be restricted to the more urgent needs facing us.

Early diagnosis is the real aim of the Health Examination Service. Prevention is mainly through education of the patient, and through his regular *practice* of the essential knowledge and advice which he receives. Health is a complex concept and cannot be measured as a whole. If the early signs of departure from

health are detected, the greatest good will be the result.

There are two essential elements in a health examination by a physician:

1. Estimating the reserve forces of the patient.
2. Prescribing a regimen and habit that are within the power and desire of the patient to follow.

Mohamet failed when he tried to make a mountain come to him; but he accomplished his object by going to the mountain.

ORIGINAL ARTICLES

EARLY CARE OF DEPRESSED FRACTURES OF THE MALAR BONE

Chief in Surgery, Atlantic City Hospital

Read before Surgical Section of New Jersey State Medical Society, June 5, 1940.

may depress the bone in mass, while a tangential blow may cause no more than a contusion.

ANATOMY

The malar bone articulates with the zygomatic process of the temporal bone, with the zygomatic process of the frontal bone, with

The malar bone, acting as an important support for the soft tissues of the face and for the muscles of expression and mastication, is the bulwark of the foundation that both silently and articulately expresses the emotions and helps much in the make-up of one's personality. Apparently slight injuries, such that would be negligible in almost any other part of the body, assume gigantic proportions when occurring about the face, because it is the laudable desire of normal individuals that the face present a pleasing, or at least not a displeasing, appearance.

When the vulnerable position to trauma of this bone is recognized, and the different angles of force to which it may be subjected is realized, one can readily understand why practically every case differs somewhat from others. For instance, blows at right angles to the bone

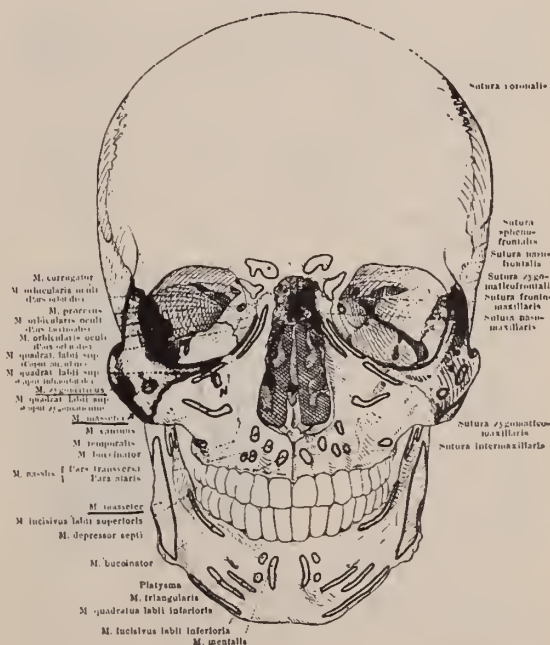


Fig. 1.—The surface relations of the malar bone.

the maxilla, and with the orbit. Each of these articulations have a corresponding process from the malar bone. The maxillary antrum lies underneath the articulation with the maxilla.

We therefore recognize a rather strong bone that is supported on four rather weak supports, and this accounts for the variety of fractures to which it may be subjected.

Also, of somewhat secondary importance, the malar bone is perforated by two nerves,—the zygomatico-facial, which gives sensory innervation to the skin over the malar bone; and the zygomatico-temporal, which gives the sensory supply to the skin about the external canthus of the eye, and posteriorly towards the external auditory meatus. These nerves may be temporarily or permanently damaged by the fractures.

MECHANISM OF FRACTURE

All of these fractures are produced by direct force. Two boys are running to catch a ball and they collide—the skull of one striking the cheek bone of the other forcibly; a person is thrown against the dash-board when a car is stopped suddenly; a baseball is thrown forcibly, striking the cheek bone.

DIAGNOSIS

Once one recognizes the typical appearance of this injury, there will be no further difficulty in diagnosis.

1. There is obvious depression in the region of the prominence of the cheek, and usually a depressed area posterior to the external canthus of the eye.

2. The lower part of the face, in contrast, is prominent and full.

3. There will be subconjunctival and palpebral hemorrhage.

4. The lower eyelid sags downward, showing too much sclera of the eye. These are all seen with a glance of the eye, i. e., by inspection alone.

Proceeding further:

1. We can feel the depression of the cheek bone, and the depression posterior to the external canthus.

2. We now proceed to the palpation of the various processes—the zygomatico-malar articulation is notched, the fronto-malar articulation is notched, and the infraorbito-malar articulation is notched. (Normally these articulations are barely palpable.) Occasionally crepitation may also be elicited. Palpation through the mouth may reveal crepitus.

There may be so much swelling that depression may not be noticed on inspection; but if palpatory evidence of depression is present, one can rest assured of the diagnosis.

Subjectively there may be a complaint of pain on mastication because of the attachment of the masseter muscle; or there may be pain or loss of sensation over the cheek region because of injury to the zygomatico-facial nerve, or pain in the temporal region because of injury to the zygomatico-temporal nerve.

X-ray examination is not needed to establish the diagnosis. It is valuable, however, in determining whether there are other fractures—such as the superior maxilla, or the coronoid process of the mandible. Occasionally it will be helpful in determining whether the antrum has been crushed. The x-ray should be utilized in every case for obvious reasons.

TREATMENT

Vilray P. Blair states, "Displacement which is allowed to persist until natural fixation occurs, too often eliminates the possibility of correction or restoration by surgery."

These fractures unite as a rule by the end of the third week. Therefore active treatment should be instituted much before that time. One of my cases did not present himself for treatment until the end of three weeks. Reduction was most difficult. The other four cases were seen immediately, and were operated upon as soon as the swelling had subsided—usually about the end of one week. Rapid reduction was easy in these cases.

Reduction of the depressed malar bone is, in my opinion, best accomplished by the method described by Gillies, Kilner, and Stone. This method is chosen because, even though it is simple, it is a positive method.



Fig. 2.—Raising the depressed malar bone.

GILLIES TECHNIC

The hair is shaved from the temporal region, and a transverse incision about one inch long is made in the temporal region, well within the hair-line. The edges are retracted, and a nick is made in the temporal fascia exposing the fibres of the temporal muscle. This nick is then enlarged so that a bone skid (Sayre's doubled-ended, blunt type is very satisfactory) about one-half inch wide, and about eight inches long, with curved blunt ends, can be passed between the fascia and muscle downwards through the temporal fossa, so that the convex curve of the instrument rests against the posterior aspect of the malar bone. This is surprisingly easy to accomplish.

Now place a pad of gauze or cotton along the upper edge of the incision to protect the skin against too much pressure and, using the skull as a fulcrum, lever the malar bone into position. Accurate reduction can be carried out by palpating the temporo-malar, fronto-malar, and infraorbital-malar articulations. When these points show good position, the bone as a whole is properly reduced. The lever back of the bone and the other hand in front of the bone allows one to make very gentle and accurate reduction. The instrument is now withdrawn and the skin closed with clips, black-silk, horse-hair or Allegheny Steel. Do not place the sutures too closely and use inter-

rupted sutures to allow for possible drainage. Don't drain the wound.

If the wall of the maxillary sinus has been crushed, the inferior support of the malar bone has been removed and the malar bone will not remain in position. In fact, after reducing the malar bone as above, if one finds that the bone slips out of place easily, one can be sure that the antrum has been crushed. In this case, proceed to the second step of the operation. The angle of the mouth is retracted and a one-inch incision is made in the canine fossa down to the bone. Push the periosteum away from the maxilla, and feel for the zygomatic ridge of the maxilla. Open the antrum just anterior to this ridge, using a quarter-inch-sized gouge. Pass a suitable curved instrument into the antrum and elevate the wall of the antrum. As soon as this has been accomplished, the malar bone will remain properly reduced.

Now pack the antrum with one-inch-wide vaseline gauze, and close the mucous membrane around the gauze with black silk. Place a gauze pack in the labio-gingival fold.

POST-OPERATIVE TREATMENT

Leave the packing in the antrum for one week and then remove it. Following this, the antrum should be irrigated daily for one week and then twice a week. The oral opening into the antrum will usually close in about three weeks.

The patient should not be allowed to sleep on the injured side for three weeks.

CASE 1

Case No. 2540—J. W., aged 22. Admitted to Atlantic City Hospital. Collided with another ball-player and was knocked unconscious. After reaction he complained of numbness and pain in right side of face, and showed the typical findings of depressed fracture of right malar bone. X-ray revealed separation of fronto-malar and infraorbital-malar articulations and fracture of maxilla and antrum.



Fig. 3.—Case 1.

Operation was performed on the fifth day after the injury, consisting of elevation of malar after

the method of Gillies, and elevation of antral walls through the oral approach. The antrum was packed with vaseline gauze. Sutures in the scalp were removed on the fourth post-operative day; and packing was removed forty-eight hours after operation. The sinus was irrigated daily for one week, and was closed at the end of three weeks. The patient caught a cold one week later, and sinus infection flared up. The sinus was then easily reopened, and irrigated frequently. Healing occurred and all evidence of sinus involvement had disappeared at end of ten weeks.

Examination approximately six months after injury revealed a perfect cosmetic result. There was hyperesthesia over the zygomatico-fascial nerve distribution.

CASE 2

Case No. 9943—E. W. P., aged 25. Admitted to Atlantic Shores Hospital. Fell asleep while driving; the car went off the road, and he was thrown out of the car. The patient was unconscious on admission, and had lacerations about face and depressed fracture of malar bone. X-rays were negative. Crepitation was felt over the antrum.



Fig. 4.—Case 2.

Operation was done 12 days later by the oral approach to the antrum. The antral walls were elevated, and it was thought that the malar depression had been corrected by this route. The antrum was packed with vaselline gauze. The Gillies approach was not used.

The antral packing was removed at the end of one week. Healed at end of three weeks—irrigations had been used as already described.

Examination four months later shows a passable, but not satisfactory, reduction. The fronto-malar articulation is notched, there is slight depression of the bone as a whole. He has hyperesthesia over the zygomatico-temporal nerve distribution.

CASE 3

Case No. 2173—B. W., aged 17. Admitted to Atlantic City Hospital. About *three weeks previously* the patient had collided with another ball player. His mother noticed the deformity in side of face, and brought him to hospital for correction of deformity. The x-ray revealed a fracture of the maxilla and notching of infraorbital and frontal articulations.

Operation was performed third day after admission, and consisted of malar elevation after the technic of Gillies. The antrum was then opened through the mouth, and the walls elevated—until this was done the malar bone could not be held in place. The antrum was then packed with vaseline

gauze. The malar elevation was very difficult, as it was necessary to break up the fixation that



Fig. 5.—Case 3.

had occurred during the three weeks before being seen. This gave rise to a very marked swelling of both eye-lids, and extensive subconjunctival hemorrhage. At the end of three weeks the wounds were healed and have remained so. Examination about six months after operation reveals an excellent result.

CASE 4

Case No. 3554—M. M., aged 23. Admitted to Atlantic City Hospital July 15th, 1938, following an automobile accident in which she was thrown against the dash-board or windshield. There were a marked amount of swelling on the left cheek, subconjunctival hemorrhage on left, and malocclusion of teeth, the left upper bicuspid area being displaced to the right. X-ray revealed a fracture of the left antrum; and the entire superior maxilla fractured just above the apices of the teeth, and avulsion of the malar bone. There was notching at all three malar sutures.



Fig. 6.—Case 4.

Eight days after admission, a Gillies approach elevated the malar bone; the antrum was opened through the mouth and packed with vaseline gauze. A small block of wood was then placed between the teeth on both sides. A skull cap was made of Stockinette and adhesive; and a sheet of rubber dam was attached to the cap in front of left ear, and carried beneath the chin and up to the adhesive in front of the right ear. This maintained continuous traction on the maxilla fracture, and that in turn held the malar bone in place.

The patient was discharged from the hospital nineteen days post-operative with all traction and gauze packing out.

CASE 5

Case No. 525—L. R., aged 40. Admitted to Atlantic City Hospital October 2, 1939. One week before, she tripped at home and struck the left side of her face on the floor. Her face became very swollen, but when first seen by writer the swelling had subsided. There was flattening of the malar region and to the side of the left orbit with notching at all three malar sutures; and the lower lid sagged.

An operation was done on the day of admission, and a Gillies approach allowed reduction of the malar displacement. The antrum was opened through the mouth; its walls were elevated, and the antrum was packed with vaseline gauze.



Fig. 7.—Case 5.

The patient was discharged seven days after operation, after removal of vaseline gauze. She was then treated at my office daily for irrigation of the sinus for one

week, and then every other day. The sinus had healed at the end of three weeks post-operative.

DISCUSSION

Five cases have been presented. It is possible to break up the callus as long as three weeks after injury. The difficulty experienced in the late operation serves to point the way to early and adequate reduction.

The second case would seem to poignantly focus one's attention to adequate treatment, as I am satisfied that, had the Gillies approach been used simultaneously, that the result would have been excellent instead of merely passable. Therefore, early and adequate operative treatment should be used in these cases.

Of the greatest importance, however, is the early recognition of these cases, and the realization that something positive can be accomplished for them.

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THE PHYSICIAN AND THE PHARMACIST

By JOHN J. DEBUS, Ph. G., Jersey City, N. J.

Chairman, Committee on Pharmaceutical Education and Standards, New Jersey Pharmaceutical Association; President, Hudson County Retail Druggists Association; and Member, Board of Pharmacy of the State of New Jersey.

Published by request of the Committee on Pharmaceutical Relations of The Medical Society of New Jersey, Chester I. Ulmer, M.D., Chairman.

Pharmacists are as much a part of the practice of medicine as they would be if they were actually in the personal employ of physicians. They may be regarded as technicians, since it is their responsibility to identify, gather, select, preserve, combine, analyze, and standardize the many medicines required by physicians to safeguard public health. Considering, however, the historical background of the circumstances which gave pharmacists official recognition as physicians' technicians, and in light of the relations between physicians and pharmacists as they exist today, pharmacists often ask themselves, "Does the Doctor realize what he is doing?"

One hundred and twenty-four years ago, recognizing the public need for the standardization of drugs, organized medicine accepted the suggestion made by Dr. Lyman Spalding to the Medical Society of the County of New York, and put into motion a project that re-

sulted in the formulation of a National Pharmacopoeia in 1819. This gave American physicians, for the first time, uniform standards for the more important drugs and preparations they then used. The Pharmacopoeia has been revised periodically ever since; and besides being recognized as the legal standards for the drugs included, it is the outstanding compendium of its kind in the world.

THE NEW JERSEY PHARMACEUTICAL ASSOCIATION

About fifty years after the need for uniform standards for drugs and medicines had been met satisfactorily, an increasing population in urban centers caused New Jersey physicians to recognize the need for more adequate control over the practice of pharmacy. Recognizing the danger to public health from the uncontrolled sale of drugs and medicines, The Medical Society of New Jersey, at its Annual Meeting on

May 28, 1867, adopted the following resolution that was introduced by Dr. Theodore R. Varick, Jersey City, who had been President of the State Medical Society in 1863:

"Whereas, this Society has been forcibly reminded, by the experience of its members, that the utter incompetency of many persons who are in the habit of dispensing medicines, has led to very serious results, involving loss of life, as in the late case in Brooklyn; and whereas, in the opinion of this Society, some stringent measures should be adopted to prevent these mistakes;

"*Resolved*, That this Society do memorialize the Legislature to enact a law requiring that all dispensers of medicines, whether they be principals or clerks, shall be either regular medical practitioners, or shall be graduates of some recognized School of Pharmacy; or in lieu of this, that all persons dispensing medicines shall pass an examination before Committees to be appointed by the County Medical Societies, said Committees to consist of one Physician and two Apothecaries who shall be graduates in Pharmacy.

"*Resolved*, That a Committee be appointed to draw up such memorial, to present it to our legislative body, and to see that it is duly attended to, and followed up with vigor."

The resolution was adopted, and the following physicians were appointed on the committee,—Drs. Varick, Jersey City; William Piereson, Orange; and Charles Hodge, Jr., Trenton. This committee—called the *Committee on Dispensers of Medicines*—made a verbal report of progress to the Annual Meeting of the State Society on May 27, 1868. The committee then worked through a local committee of the Essex County Medical Society in coöperation with an informal committee of druggists, with the result that on March 24, 1870, the pharmacists perfected a State-wide organization of their own—the New Jersey Pharmaceutical Association. This is the oldest State Pharmaceutical Association in the United States. It was incorporated by act of the Legislature on February 18, 1874; and secured the passage of the first pharmacy act on March 9, 1877.

Ever since its organization, the New Jersey Pharmaceutical Association has sought to elevate the standards of the profession, to improve its art, and to restrict the dispensing, compounding, and sale of medicines to properly qualified pharmacists. That these efforts have met with success is indicated by the fact that New Jersey's standards of requirements for

admission to examination for certification as pharmacist are the highest of any state in the Union, and that today the dispensing, compounding, and sale of medicines to the public is under competent supervision.

ATTITUDE OF PHYSICIANS

It may properly be concluded that physicians are to be credited with the establishment of adequate legal standards for drugs and medicines, and for the inauguration of a system which precludes the possibility of dispensing, compounding, or selling drugs and medicines except under competent supervision. In the fruition of these efforts, physicians rendered a great public service. However, a review of the prescription files of any New Jersey pharmacy will show that too many physicians have apparently lost faith in the legal standards which they caused to be adopted for drugs and medicines, and in the ability of pharmacists to compound preparations of drugs. The trend away from recognized standards for drugs and medicines is equally detrimental to the best interests of the physician, the public, and the pharmacist; and has had some influence in the recent revision of the Pure Food and Drug Law.

ATTITUDE OF THE PUBLIC

The public is more *self-medication* conscious than ever before; and physicians have helped to bring about the condition. If physicians had continued to use the drugs for which they sought and secured legal standards, and had utilized the talents which through their efforts were developed in pharmacists for compounding the preparations of these drugs, the picture might have been different today, and there might not have arisen the necessity for giving legal recognition to self-medication by amending the Pure Food and Drug Act to provide for the better labeling of drugs in order to bring the public more complete information regarding their proper administration for self-medication purposes.

EFFECT ON THE DRUGGISTS

Pharmacists often wonder whether or not physicians fail to recognize the great harm that is resulting from their growing tendency to

prescribe and recommend advertised medicines identified by easily remembered trade names. Such practice, in many instances, appears to be a direct slap at the pharmacist, who is made to feel that the physician very deliberately insinuates that he has no confidence in the druggist as a professional compatriot; and that he does not have the ability to prepare the simple pharmaceutical preparation which the physician prescribed under a coined trade name. This evident lack of faith in the ability of the pharmacist is certainly not in accordance with the attitude of the members of the medical profession who originally urged pharmacists to assume their own professional stature and responsibilities; and it is not conducive to much enthusiasm on the part of pharmacists to continue their struggles to elevate their standards to still higher levels.

The pharmacist wonders also what sort of neighbor the physician can be, when he prescribes trade-named, prefabricated medicines, for by so doing the physician prevents the pharmacist from earning a compounding fee, and allows it to be earned by the producer of the medicine. In all except very rare instances, the producer of ready-mixed drugs cannot be considered a neighbor, or even a friend, of the physician, or his patient, or the pharmacist, as there is every indication that the producer's only interest is to sell as much of his medicine as possible for the sake of profits, none of which remain in the community in which the physician, his patient, and the pharmacist earn their livelihoods.

SELF-MEDICATION

Again, pharmacists wonder if physicians are actually blind to the fact that they are helping the cause of self-medication when they prescribe or recommend prefabricated medicines identified by short, euphonious trade names. The public has been made conscious of prefabricated medicines with easily remembered trade names as single cures for any individual's condition; and they fail to realize that, when a doctor prescribes a short-named, factory-made medicine, he may have intended it to fit the patient's individual condition. Consequently, when similar symptoms again set in, either in

the original patient, or a neighbor, it is the most natural thing for the patient to assume that, since what the doctor originally ordered is a prefabricated medicine, it will help the condition again.

Patients are also commencing to think that it is the smart thing to do to read the doctor's prescription, and to purchase the prescribed medicine in the original package. In either event, the physician lends aid to a movement which is at variance with the aims and ideals of his profession. He fails to fulfill his professional obligation to protect the best interest of his patient; he jeopardizes his own best interest when he gives even the slightest encouragement to the evil of self-medication; and he does not give encouragement to scientific pharmacy when he prescribes many pharmaceutical compounds under coined trade names.

THE NEW JERSEY FORMULARY

It is heartening to note that leaders of the medical profession in New Jersey are once again recognizing the dangers involved in a fast-growing evil, and have taken measures to bring about its correction. The Joint Committee on Professional Relations, consisting of an equal number of representatives of the New Jersey Medical Society and the New Jersey Pharmaceutical Association, under the chairmanship of Dr. Chester I. Ulmer of the Medical Society, is guiding a program which is designed to acquaint prescribers of the dangers involved in the innocent practice of writing for medicines suitably adapted for self-medication purposes. Through the New Jersey Formulary, the official compendium of the New Jersey Medical Society and the New Jersey Pharmaceutical Association, a number of formulas are made available to physicians and pharmacists for use in the compounding of preparations which are similar to proprietary specialties. Through this means it is hoped that physicians will ultimately refrain from innocently lending aid to the self-medication movement; and will prescribe drugs and medicinal preparations which will give the best results to their patients, without encouraging them in self-prescribing.

PROBLEMS ENCOUNTERED IN THE DIAGNOSIS AND TREATMENT OF UTERINE CANCER

By LEWIS C. SCHEFFEY, M.D.

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Presented at a meeting of The Medical Society of New Jersey at Atlantic City, N. J., June 4, 1940, before the Combined Sections on Surgery and Obstetrics and Gynecology.

There is no more important or more frequently discussed subject in gynecology than cancer of the uterus. Speculation regarding its causation, excitation, and development is provocative of unending discussion; but until an exact answer is found the clinician is confronted with facts that have to be faced, rather than with theories that stimulate one's imagination. I shall limit my discussion, therefore, to those problems in the diagnosis and management of uterine cancer that are of practical importance to all of us. My remarks are based on personal experience, combined with observation of the work of others, and the conclusions drawn are to be interpreted in that sense, for the opinions of others may offer more basis for justification than those herewith presented.

1. CANCER OF THE CERVIX

DIAGNOSIS

Cancer of the cervix is encountered, on the average, about ten times as frequently as cancer of the fundus. Usually—I repeat usually—the symptomatology is distinctive: abnormal vaginal bleeding of some sort, although in a small number of patients no irregularity whatsoever has been noted. Watery or leukorrheal discharge is an unreliable symptom unless blood-tinged; it is certainly not pathognomonic of cancer, and is more frequently due to benign causes.

Pain, as a significant symptom, is only of value in calling attention to the desirability of a pelvic examination.

Why then is prompt diagnosis so frequently delayed? I think several factors are responsible, and I mention them,—first, those related to the patient; and second, those related to the medical profession.

FACTORS RELATING TO THE PATIENT

Either because of modesty, ignorance, or actually because of fear of learning the truth,

women are often loath to submit to a pelvic examination, even though aware of the fact that something is radically wrong.

Furthermore, as the menopause is approached, reliance is often placed on the popular conception that menstrual irregularities are to be accepted as a matter of course and the optimistic opinion of friends or neighbors often tends to encourage this belief.

Finally, economic conditions, or a disinclination to “worry the family”, delay initial consultation.

FACTORS RELATING TO THE PHYSICIAN

Only too frequently women approach physicians who do not realize the urgent need of making a thorough pelvic examination when she consults them because of abnormal bleeding. I emphasize this point because time and again this unfortunate truth is brought out in the preparation of a careful clinical history. A douche may simply be prescribed, hormonal therapy instituted, or pelvic examination postponed “until the bleeding stops”. Thus valuable time is lost in making a prompt and exact diagnosis.

Too often cervical cancer is regarded solely as a disease of later life, and the possibility of its occurrence in earlier decades is not even considered. Statistics on the gynecologic service at Jefferson Medical College Hospital show that 30 per cent of 370 patients were 41 years of age or younger when the diagnosis was established. Cervical cancer must always be thought of as a possibility throughout the entire reproductive period, as well as during or following the menopausal epoch.

The preponderance of cervical cancer among multiparous women sometimes causes us to lose sight of its occurrence in the nullipara. Tompkins, in a painstaking review in 1935, estimated that in the United States in 1930, among women 30 years of age or more, the death rate

from cervical cancer was at least half as great among those who had not borne children as among those who had. While this study is only an isolated bit of evidence, it does show the potentiality of cancer developing in the nulliparous cervix. In our series at Jefferson, the percentage of nulliparous patients with cervical cancer between 1921 and 1940 is 8.4 per cent—a substantial group.

Cervical cancer extends insidiously, but comparatively rapidly; hence broad ligament involvement is relatively early, sometimes however with a paucity of symptoms. In spite of the vigorous campaigns being conducted, we are seeing but little change in the number of so-called "early cases". At Jefferson, for instance, from 1921 to 1930, 11.5 per cent of the patients exhibited group one and two lesions; from 1930 to 1939 this figure rose to 12.2 per cent, a relatively small increase. From this evidence, it can readily be seen how "cancer-conscious" and alert one must be.

FACTORS FAVORING IMPROVEMENT

Bearing the above factors in mind, how can relatively early cases of uterine cancer be discovered, diagnosed and treated? Only by looking for it whenever the opportunity for a pelvic examination presents itself; and by urging in all possible ways the advantage of periodical inspections. Obstetricians do, or should, recognize the advantage offered them in this respect by impressing upon the post-partum patient the importance of such examinations. The general practitioner has a like opportunity, but an added responsibility as well, since he is generally the patient's first medical adviser.

Facilities for examination should be adequate. Good exposure, sufficient illumination, and a few essential instruments are easy to provide. Nothing is simpler than early biopsy of a suspicious cervix in making a prompt diagnosis of cervical cancer. Schiller's test and the colposcope help to a certain extent, but the histologic examination should be the court of first resort.

A word should be said about the use of hormonal therapy in the control of uterine bleeding. Its use should be rational, and based on the exclusion of cervical cancer (and of course

other organic pelvic lesions), by thorough pelvic examination. This warning is especially pertinent, since it has been shown how large a proportion of this type of cancer occurs before the menopause, when the irregularity can readily be mistaken for functional bleeding and treated as such. Such errors have occurred not infrequently in our series.

TREATMENT OF CERVICAL CANCER

PROPHYLAXIS

Discussion of the treatment of any disease begins with prophylaxis. From time immemorial traumatism of the cervix was considered to be the most likely etiologic factor in the development of cancer, and much effort has been directed to effect the correction of cervical lesions as a preventative measure. More recently the rôle of hormonal influence in carcinogenesis has caused us to pause in placing the sole blame on chronic irritation. Nevertheless, the preponderance of cervical cancer among multiparous women offers sound reasons for indicated and adequate treatment of the lacerated, eroded and chronically diseased cervix.

THERAPY

While the question of radical surgery rather than radiation therapy is only controversial in treating early carcinoma of the cervix, we are confronted with the fact that the vast majority of patients, as has been stated, have advanced lesions when they apply for treatment. If, in the early case, surgery is to be considered at all, simple panhysterectomy will not do; only the extensive Wertheim procedure will suffice.

At Jefferson we have not employed surgery for cancer of the cervix since 1924. Our radiation therapy has undergone three fundamental phases:

1. In the earlier days radium alone was employed almost entirely.
2. Later post-radium x-ray therapy was used in addition to radium.
3. Since 1935, the use of x-ray has preceded the use of radium.

Sufficient time has not elapsed since the institution of the third plan to evaluate it by com-

parison with former methods. An advantage seems to be a marked regression of foul, sloughing, and bleeding lesions prior to the radium application. Possibly, too, more deeply seated cancer cells are affected, and, together with those more superficial in location, devitalized, so that subsequent radiation with radium becomes more effective.

On the other hand, distinct disadvantages are the severe reactions often encountered—dermatitis (sometimes ulcerative), gastroenteritis, and local vaginal vault contractures that frequently make later radium applications difficult.

X-ray Application.—The present plan of preliminary radiation is carried out by the Department of Roentgenology under the direction of Dr. Karl Kornblum. High-voltage therapy employs the following factors: 200 kilovolts, 30 milliamperes. Filtration is one-half millimeter of copper, plus one millimeter of aluminum, with 50 centimeters target skin distance.

Multiple portals are employed about the pelvis, crossfiring on the uterus. The number and size of the portals is dependent upon the build of the patient. They may vary from two to eight in number. In the average case, four portals, each 20 by 20 cm. in size, are used,—two anteriorly and two posteriorly. Two such areas are treated daily, each receiving 200 roentgens. Such treatments are continued until a well-marked erythema is obtained which in general will occur with 1600 to 2400 r to each portal. Such a series requires about two to three weeks for completion.

Radium Application.—Immediately afterward, or within a few weeks, radium is applied locally unless the lesion is so far advanced that it is thought best to rely upon x-ray radiation alone. One, two, and sometimes three 50 mgm. capsules of radium, screened with 1.5 mm. of platinum, and placed in special tubing of black rubber, are placed in tandem (or singly) in the cervical canal and uterine cavity. Ten 10 mgm. needles, screened with 0.5 mm. of platinum, are employed interstitially throughout and about the periphery of the growth, sometimes extending to the bases of the broad ligaments. A dosage ranging between 3600 and

5000 milligram hours is used, depending upon the individualization of the particular patient under treatment. The vagina, rectum, and bladder are carefully displaced from the radium by the judicious use of gauze packing, and a self-retaining catheter is placed in the bladder to keep it constantly empty.

A careful follow-up system is essential in evaluating treatments, observing the progress of the patients, deciding upon reradiation, and computing salvage. To be most effective, this requires the personal supervision of the surgeons and radiologists in charge. At Jefferson the follow-up percentage ranges between 98 and 99 per cent. Reradiation has played an important part in our salvage of patients.

RESULTS OF TREATMENT

The term "five-year cure" is a misnomer. We have observed patients who have died from a return of cervical cancer as late as eight to twelve years after their initial treatment. Hence, we prefer to use the term "salvage" throughout the observation period. In a recent study we noted the interesting fact that 46.2 per cent of patients alive from five to sixteen years after their initial treatment owed their prolongation of life to a second course of radiation for recurrence.

From 1921 to 1935, 273 patients with carcinoma of the cervix were seen on the Gynecologic Ward Service at Jefferson, of whom 259 were treated. Only six patients are untraced. The results are:

1. Five-year salvage (including cancer deaths)	{ 22.3% (AB) 23.5% (REL)
2. Five-year salvage (excluding cancer deaths)	{ 16.8% (AB) 17.7% (REL)
3. Present-day salvage (alive 5 to 18 years)	{ 15.0% (AB) 15.8% (REL)

The results of treatment in the relatively few Group I and II patients were twice as satisfactory as those in Groups III and IV.

2. CANCER OF THE FUNDUS

DIAGNOSIS

While some of the foregoing remarks relative to the problems encountered in the diagnosis of cervical cancer apply equally to those associated with the diagnosis of fundal cancer,

certain factors regarding cancer of the body of the uterus may be viewed from a different aspect.

The age factor is important, for fundal cancer is found three times out of four in women over 50 years of age. Only four per cent in our series were under 41 years of age, as contrasted with the 30 per cent of women under 41 years of age who developed cervical cancer. Hence it is chiefly a disease of the menopausal and post-menopausal epochs.

The nulliparous incidence is high, being 35 per cent in our series, indicating that prior pregnancy has little or no influence as a predisposing factor.

Usually the irregular bleeding is post-menopausal in nature, although it is sometimes difficult to establish the fact as to whether or not the menopause had actually occurred, the irregular bleeding being regarded simply as a prolongation of it. However, in 75 per cent of our patients the principal symptom was post-menopausal bleeding in women whose average age was 59 years; while in 25 per cent, having an average age of 46 years, there had been cessation of menstruation when menorrhagia or metrorrhagia occurred.

These observations would seem to justify a presumptive diagnosis of fundal cancer in the relatively older woman who has developed post-menopausal bleeding, and diagnostic curettage will promptly settle the question. It is in the minority group of women under 50 years of age that error or delay in diagnosis is most frequently encountered. Bleeding from the cervical canal is observed, the cervix may be intact or even atrophic, and in such instances there is often a tendency to procrastinate, instead of promptly performing or advising diagnostic curettage.

In comparison with cervical cancer, the growth of fundal cancer is relatively slow, since it is limited to the endometrial cavity long before infiltration of the myometrium, or extension to the adnexa and lymphnodes takes place. This fact, together with the very significant type of bleeding encountered, should facilitate early and accurate diagnosis, with the institution of appropriate treatment, followed consequently by a better prognosis.

Hormonal Therapy.—Certain confusing therapeutic errors may likewise retard early and correct diagnosis of fundal cancer. As has already been stated with regard to the delayed diagnosis of cervical cancer, the widespread use of hormonal therapy for functional bleeding at the time of the menopause and afterward has not infrequently led to inexcusable delay in diagnosis. This is not only true of the relatively younger woman, whose menstrual flow has never ceased, and who is experiencing marked irregularity, but equally so of the older patient who exhibits post-menopausal bleeding. Hormonal therapy at this time of life, without diagnostic curettage, cannot be too strongly condemned. Furthermore, bleeding due to benign causes can be controlled to better advantage by more suitable procedures than hormonal therapy at this time of life, when cessation of menstruation should occur in the natural course of events.

Myoma and Cancer.—Another source of error in diagnosis is the assumption that a myoma, discovered in the elderly patient, is the sole cause of menopausal or post-menopausal bleeding, and inadequate treatment may result thereby. The not unusual association of myomata with cancer of the endometrium (25 per cent in the Jefferson series) adds weight to this possibility of error. Hence the selection of radium or x-ray therapy for the cure of myomata should always be preceded by, or accompanied with diagnostic curettage.

TREATMENT OF FUNDAL CANCER

PROPHYLAXIS

The presence of myomata has been thought to predispose to the development of fundal cancer, possibly because of the deficient drainage from the endometrial cavity that might ensue. Along the same line of thought is the supposition that stenosis or atresia of the cervical canal, resultant from congenital causes, inflammatory changes, cauterization, or polyp formation, may be a provocative factor because of resultant inadequate drainage. Eradication or correction of such abnormalities is perhaps of prophylactic value.

THERAPY

Panhysterectomy, preferably abdominal with removal of the adnexae, has been and is probably the most widely accepted treatment for cancer of the fundus whenever practicable. Radiation alone is relied upon by some. More recently preoperative radiation has been adopted by many as a desirable procedure, together with postoperative x-ray radiation in selected instances. In our opinion, the patient with fundal cancer must be strictly individualized as regards treatment, because many factors are involved which require further discussion.

The procedure followed at Jefferson in the management of fundal cancer has proven advantageous in our hands, and in those of others. When malignancy is suspected, small 50-mgm. capsules of radium are available at the time of the diagnostic curettage, for insertion into the uterine cavity. One or more may be used dependent upon its depth and regularity.

Rapid examination of the curettings, not frozen sections, determines the length of time that the radium is to be allowed to remain in situ. If the lesion is benign, suitable dosage for such a type of lesion is employed. Should the curettings prove to be malignant, the type of cell is considered in relation to dosage and future therapy. Also to be considered are the extent of the disease, and the general condition of the patient.

Subsequent panhysterectomy is carried out in six to eight weeks whenever feasible, followed by deep x-ray therapy only if it is believed that possible extension or metastases have occurred.

The term "five-year cure", as previously stated, is just as much a misnomer in fundal as in cervical cancer. It seems probable, however, that the prognosis in fundal cancer does depend to some extent at least, upon the type of cell encountered,—a finding which is not applicable to the various grades of malignancy noted in cervical cancer. This supposition should not be confused with the question of tissue radiosensitivity, to which, however, it is related.

It has been demonstrated by Healy and others, and observed by ourselves, that the low-grade type of malignancy seen in fundal can-

cer, designated by some as "papillary adenoma malignum", and "adenoma malignum" (Grades 1 and 2), has been treated effectively either with surgery or radiation or a combination of both.

On the other hand, fundal cancers of intermediate or high-grade malignancy, spoken of as "glandular adenocarcinoma" or "solid adenocarcinoma" (Grades 3 and 4), seem to have a decidedly poorer prognosis, and have been treated to better advantage either by radium and surgery in combination, or even by radiation alone, than solely by surgery.

In well-advanced lesions, radiation must be relied upon entirely, and this is nearly always true of elderly, obese individuals, and of poor operative risks in whom cardio-vascular, cardio-renal, and diabetic disease exists. Where obesity is pronounced, x-ray is poorly borne and ineffective, and radium had better be depended upon in these instances. The application of radium, too, presents definite limitations sometimes, because the uterine cavity may be distorted and irregular, by virtue of concomitant myomata, as Sampson's careful investigations have shown. In isolated instances of exceptionally large fibroid tumors in menopausal patients who are good surgical risks, and in whom the possibility of endometrial cancer exists, it may be well to do a primary panhysterectomy without preliminary curettage and preoperative radiation with radium.

RESULTS OF TREATMENT

From 1921 to 1935, 62 patients have been seen on the ward and private gynecologic services at Jefferson, of whom 61 were treated, and none are untraced. The results are:

1. Five-year salvage (including cancer deaths)	{ 40.3% (AB) 40.9% (REL)
2. Five-year salvage (excluding cancer deaths)	{ 33.8% (AB) 34.4% (REL)
3. Present-day salvage (alive 5 to 15 years)	{ 24.1% (AB) 24.5% (REL)

In relation to the type of malignancy exhibited, the results are:

FIVE-YEAR SALVAGE INCLUDING CANCER DEATHS

1. Low grade . . . 19 patients—61.3% (47.3% alive)
2. Intermediate . . 24 patients—25.0% (8.3% alive)
3. High grade . . . 17 patients—29.4% (17.6% alive)
(Unclassified—1 patient)

In relation to the type of treatment received, the results are:

FIVE-YEAR SALVAGE INCLUDING CANCER DEATHS

1. Radiation alone 30 patients—46.6% (23.3% alive)
2. Radiation and surgery 18 patients—44.4% (27.7% alive)
3. Surgery alone. 13 patients—23.0% (23.0% alive)

No conclusions should be drawn from a series of cases as small as this. However, personal knowledge of these patients and a close study of them over a long period of time has led the author to believe that preliminary radiation with radium is a rational procedure, and that it should always be followed with panhysterectomy and adnexal extirpation whenever the patient is a reasonable surgical risk. While it is possibly true that radiation will cure the low-grade lesions, and may even offer much in malignancy of high grade, we do not like to depend upon that belief, unless subsequent surgery is definitely contraindicated, principally because an accurate radium application to the uterine cavity may not be possible. Nevertheless, the aged, the excessively obese, and the poor surgical risk patient will usually have to be treated solely with radiation. Each patient, however, should be individualized with respect to treatment. One should not attempt to standardize it.

SUMMARY

One does not like to express pessimism in regard to the ultimate cure of uterine cancer. However, an experience of nearly twenty years, with intimate knowledge of, and a careful follow-up of the results obtained in these two series of patients with cervical and fundal cancer cannot be discounted.

It would seem that, if the patients are followed long enough, we will find that eventually the majority of them will die of cancer, and that the absolute salvage will not exceed 15 to 20 per cent in the cervical group, and 25 to 35 per cent in the fundal group.

Final figures must be based on the absolute standard, and the "five-year" period of cure cannot be regarded with certainty. Until such times as the exact cause of cancer can be stated with certainty, and until such time as early diagnosis is the rule rather than the exception, we cannot hope for much better results over a long period of time.

Meanwhile we can be encouraged by the fact that we do prolong life, and in many instances happiness, by an earnest application of the present means at our disposal, which we sincerely hope may improve as time goes on.

Medical Tower

255 South 17th Street

Philadelphia, Pa.

TRANSPLANTATION OF THE URETERS INTO THE RECTOSIGMOID AND CYSTECTOMY

By CHARLES C. HIGGINS, M.D., Cleveland Clinic, Cleveland, Ohio

Read before the Combined Sections on Surgery, and Obstetrics and Gynecology of the Annual Meeting of The Medical Society of New Jersey, June 4, 1940.

Since 1852, when Simon¹ described an operative technic for diverting the urinary stream into the bowel, numerous new procedures, or modifications of previous operative technics, have been described for transplanting the ureters into the rectosigmoid. Martin,² Peters,³ Fowler,⁴ Coffey,⁵ and others have described operations to minimize postoperative complications, morbidity, and mortality.

It has been said that some obstruction of the upper urinary tract invariably follows implantation of the ureters into the bowel. This produces stasis and superimposed renal infection, and eventually death from renal sepsis and

failure. Sufficient time has elapsed since the introduction of intravenous urography, however, that such erroneous deductions may be dismissed. If the technical details of the operation have been followed carefully, the ureters and kidneys may remain in a normal or fairly normal condition for a period of years.

EXSTROPHY OF THE BLADDER

At the present time, transplantation of the ureters into the rectosigmoid and cystectomy is the procedure of choice in exstrophy of the bladder (Fig. 1). This congenital abnormality occurs approximately once in every forty to

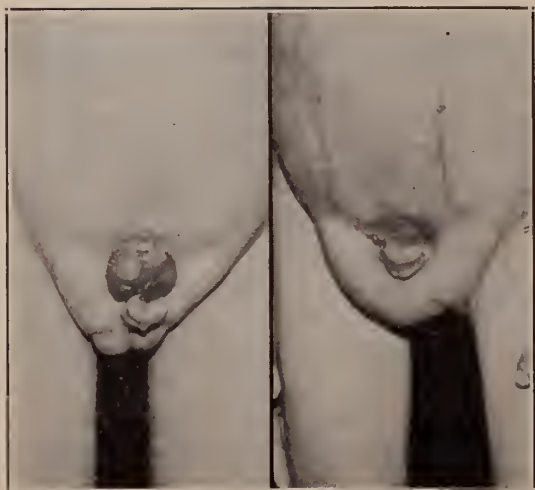


FIGURE 1

- A. Exstrophy of the bladder.
B. Photograph of patient after transplantation of the ureters and cystectomy.

fifty thousand births. As the children grow older, they become social outcasts because of the unavoidable odor which is accompanied with soiling of the clothes by urine. Without surgical intervention, 50 per cent of these children die before the age of ten years, and 66 per cent, before the age of twenty years. In the majority of instances, death is caused by renal sepsis associated with progressive impairment of renal function. Stenosis develops at the ureterovesical junction of the exposed bladder, and is followed by dilatation of the ureters, hydronephrosis, renal infection, and eventual renal failure.

Although many children die before reaching five years of age, it still is sometimes recommended that the operation be postponed until that time. From my experience of the past two and one-half years, I believe that this delay is unwarranted, and is attended by considerable risk to the child. At the Cleveland Clinic, we have transplanted the ureters into the bowel and have removed the exstrophic bladder in nine infants under one year of age. The youngest child was one month old. Satisfactory end results were secured in every instance, and these children were discharged from the hospital in excellent condition.

The majority of children who enter the clinic for operation, however, are over three years

of age. Obstruction of the ureter at the ureterovesical junction may have produced dilatation of the ureters to such an extent that they cannot be transplanted into the bowel even before the child is five years of age. In a child two years of age, and in another four years of age, a markedly dilated ureter and a large infected hydronephrosis in each child necessitated nephro-ureterectomy, which was followed by implantation of the opposite normal ureter into the rectosigmoid and cystectomy. This again emphasizes the necessity for operating during the first year of life.

Patients in whom the ureters have been implanted into the bowel are very comfortable. The two young children I wish to present to you today had transplantation of the ureters and cystectomy more than two years ago. They evacuate their bowels three times daily, and pass through the night without going to the toilet, or at least not more than once nightly. As you see, they are happy youngsters and live a normal life.

CARCINOMA OF THE BLADDER

Pronounced progress in the treatment of malignant disease in various parts of the body has resulted from early diagnosis and prompt radical surgical procedures. Although the larynx may be extirpated, a lobe of the lung may be removed, and extensive resections of the gastrointestinal tract may be performed, there still seems to be a hesitancy to advocate cystectomy for carcinoma of the bladder.

A report of the Carcinoma Registry of the American Urological Association⁶ states that 30.3 per cent of tumors of the bladder less than two cm. in diameter are controlled for five years; while only 15.8 per cent of the patients with tumors larger than five cm. were alive at the end of five years. The cause of death in a large percentage of patients with carcinoma of the bladder is not due to extension of the growth beyond the confines of the bladder or metastasis. In the majority of cases the ureteral orifices are encroached upon by the tumor producing ureteral obstruction. This is followed by stasis, infection, pyelonephritis, and the patient dies of renal sepsis and failure.

Of 902 case reports of patients with carcinoma of the bladder reviewed by the Carcinoma Registry,⁷ metastases were present in seventy-two instances only. Caulk noted metastases at necropsy in 25 per cent of his series; Beer, in 10 per cent; the author, in 12 per cent; and Smith, in reviewing the cases at the Massachusetts General Hospital, reported metastases in 40 per cent of the cases.

Caulk stated further that 60 per cent of the patients at necropsy had died a renal death. Rankin stated that since 1900, operations for carcinoma of the colon have gradually evolved satisfactory technics, and have been accompanied by a gradually decrease in mortality. I believe that cystectomy and transplantation of the ureters into the rectosigmoid in selected cases of carcinoma of the bladder will produce the same results. At the present time, cystectomy is considered an "event of last resort", and is instituted only for well-advanced carcinoma of the bladder, or when conservative procedures have failed.

Transplantation of the ureters into the bowel in patients with pronounced pyelonephritis and dilated ureters will be attended by a high mortality. When the ureters cannot be transplanted into the bowel, even if the bladder is removed *in toto*, an inguinal cutaneous ureterostomy is the procedure of choice. Carcinoma too extensive to be treated by conservative procedures often can be cured by the complete removal of the bladder, and diversion of the urinary stream into the bowel. Cystectomy and transplantation of the ureters into the bowel is indicated in the following instances:

1. When a carcinoma at the base of the bladder encroaches upon the ureteral orifices; or when the vesical sphincter is so involved that adequate local treatment would be destructive to the ureteral orifice, or would cause incontinence.

2. When extensive single or multiple infiltrating tumors are present.

3. When multiple recurring tumors develop so rapidly that they cannot be controlled by fulguration or irradiation.

This radical procedure is not indicated in all cases. The tumor may be removed by segmental resection of the bladder, even if it re-

quires re-implantation of the ureter into another portion of the bladder. Similarly, radium should be used if the tumor is small enough to be adequately treated. However, conservative treatment of extensive malignant lesions of the bladder is to be condemned in view of the results secured by radical surgical intervention.

In a miscellaneous group, transplantation of the ureters into the bowel occasionally is the only means of affording relief to the patient.

EPISPADIAS

In the majority of instances an epispadias may be cured by plastic procedures. However, in rare cases in which the defect is so extensive that the child remains incontinent after the continuity of the urethra is reestablished, transplantation of the ureters into the bowel is indicated.

TUBERCULOUS CYSTITIS

Some patients, following nephrectomy for unilateral renal tuberculosis, continue to have intolerable bladder symptoms. The markedly reduced bladder capacity necessitates voiding every few minutes. If conservative treatment does not afford relief, the urine from the remaining kidney may be diverted into the bowel. Cystectomy is not required in this group of patients.

HUNNER ULCER

The so-called elusive ulcer of the bladder or chronic interstitial cystitis is characterized by clock-like frequency of urination. With the progressive diminution of bladder capacity, voiding is necessary at frequent intervals day and night. The urine may be sparkling clear, and microscopically free from pus; and the patient may therefore be designated a neurasthenic. If these patients do not respond to conservative treatment, implanting the ureters into the bowel without cystectomy may be justified.

VESICOVAGINAL FISTULA

Although the vesicovaginal fistula may be cured by plastic operations in a majority of instances, the defect may extensively involve the sphincter and urethra; or, because numer-

ous plastic operations have failed, the operative field may be replaced by scar tissue. In these few instances, transplantation of the ureters into the bowel affords complete relief.

OPERATION

The preoperative preparation of the patient is essential in transplanting the ureters into the bowel. Five or six days are usually required to prepare the bowel, to improve the renal function, and to minimize or eradicate the renal infection.

After adequate preparation, the operative

procedure is chosen. If the Coffey I technic or one of its modications is advocated, a unilateral implantation of the ureter is preferable, followed by transplantation of the opposite ureter, with or without cystectomy, ten days later. This is advisable because on the third post-operative day, the amount of urine passing into the bowel is diminished by the sloughing of the ureteral stump protruding into the lumen of the rectosigmoid. As this sloughs off, adequate drainage is established. While the opposite kid-

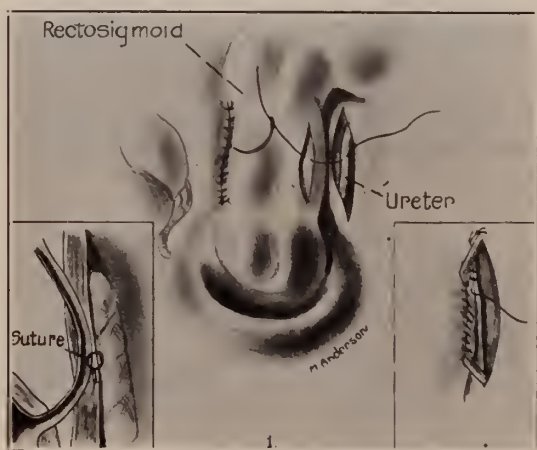


FIGURE 2A-1

Placing of transfixion suture between the ureter and the mucous membrane of the rectosigmoid.

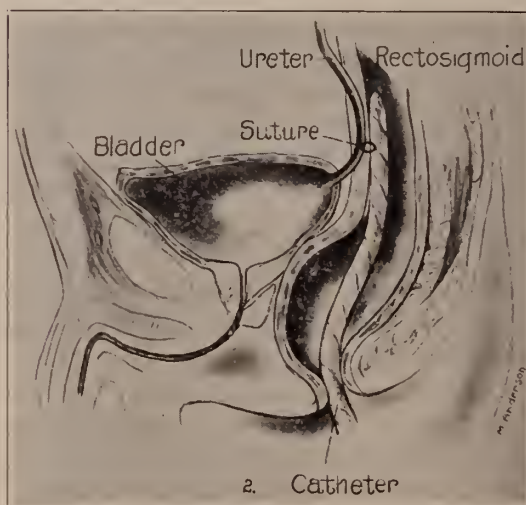


FIGURE 2A-2

Gauze-wrapped rectal tube in place. Transfixion suture between the ureter and mucous membrane of the bowel and grasping the gauze surrounding the rectal tube.

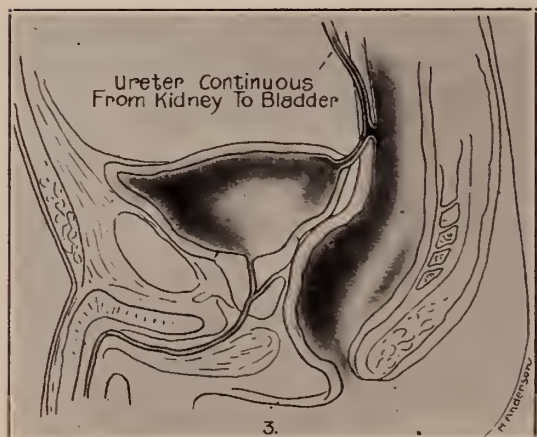


FIGURE 2A-3

New communication between the ureter and bowel established. Rectal tube and sutures have passed.

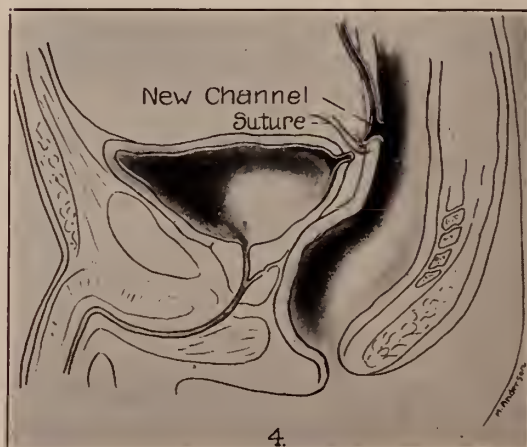


FIGURE 2A-4

Severing the continuity at the point of emergence from the trough and additional anchoring suture in place.

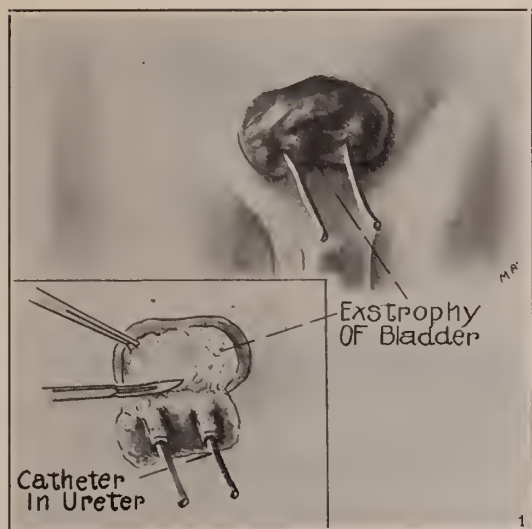


FIGURE 2B-1
Exstrophy of the bladder. Catheters in situ.

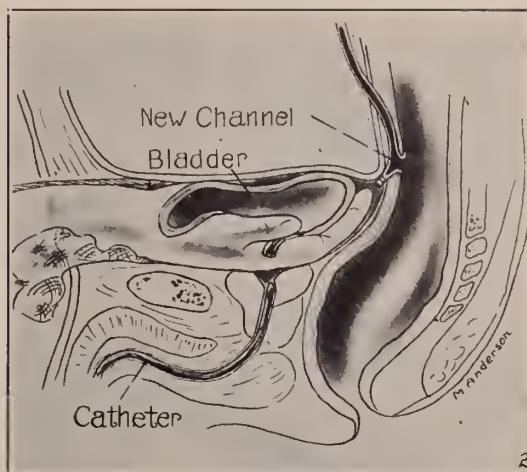


FIGURE 2B-2
The final step of cystectomy, starting at the bladder neck.

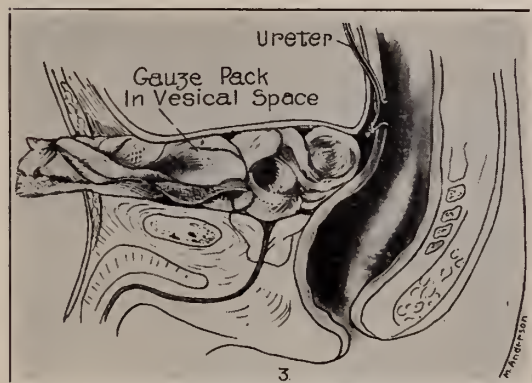


FIGURE 2B-3
Bladder completely removed. Gauze pack in vesical space.

unilateral transplantation is advised (Figs. 3 and 4), the right ureter is implanted into the bowel first. Ten days later the left ureter is transplanted with or without cystectomy.

In this series, the ureters have been transplanted into the bowel, and cystectomy has been performed in the following cases:

1. Exstrophy of the bladder	41 cases
2. Epispadias	2 cases
3. Carcinoma of the bladder	44 cases
4. Vesicovaginal fistula	11 cases
5. Vesical tuberculosis (bladder not removed)	2 cases
6. Hunner ulcer of bladder (bladder not removed)	6 cases

RESULTS

Adequate preoperative preparation, postoperative care, and refinements in operative technique have reduced mortality to a point where there should be no hesitancy in recommending this operation in indicated cases. All the infants (nine) under one year of age have been discharged from the hospital in good condition.

In older children and young adults in whom transplantation of the ureters is necessary for a similar condition, the mortality should be less than five per cent. In my series, the mortality is approximately 3.8 per cent.

If proper selection of cases is made, cystectomy and transplantation of the ureters into

ney functions normally, there is no danger of renal insufficiency. By the time the second ureter is ready to implant, free drainage is established into the bowel from the operated side.

If the bilateral transfixion technic is advocated (Fig. 2A and 2B), the ureters may be transplanted simultaneously without danger of renal insufficiency. As the continuity of the ureters is not interrupted until the new channels into the bowel are established, both ureters may be transplanted simultaneously without danger of obstructing the flow of urine. When

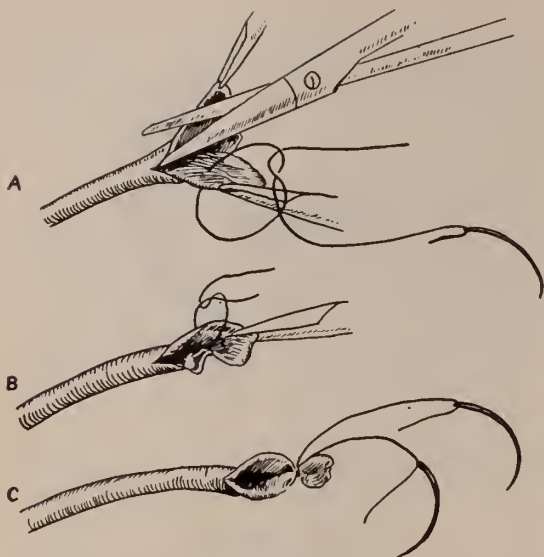


FIGURE 3

Preparation of the ureter to be transplanted into the bowel.

the bowel does not carry a high operative mortality for carcinoma of the bladder, the mortality rate being between ten and eleven per cent. If the ureters are considerably dilated, transplantation into the bowel is contraindicated by an extremely high mortality. In those cases an inguinal cutaneous ureterostomy, followed by cystectomy, is advisable.

SUMMARY

1. Transplantation of the ureters into the rectosigmoid and cystectomy are accepted surgical procedures.

2. The mortality has been reduced to a point at which there should be no hesitancy in recommending this procedure in indicated cases.

3. The patients are perfectly comfortable, and may return to their original occupations.

4. Bilateral transplantation of the ureters with the transfixion suture technic is a safe procedure.

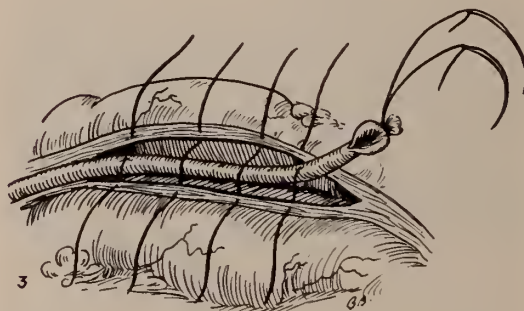
5. Unilateral transplantation of the ureters is advisable if the Coffey I operation, or one of its modifications, is used.

6. Transplantation of the ureters into the bowel and cystectomy for exstrophy of the bladder should be performed preferably during the first year of the child's life.



FIGURE 4

1. Trough made in bowel wall along white line.
2. Placing of initial suture.



3. Sutures in place for anchoring ureter into bowel wall and for closure of the trough in the bowel.
4. Final step in implanting the ureter into the lumen of the bowel.

7. Conservative treatment of extensive tumors of the bladder is to be condemned where radical surgical intervention is followed by complete eradication of the malignant disease and a reasonable certainty of a cure.

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PULMONARY FAT EMBOLISM WITH RECOVERY

By IRVING L. APPLEBAUM, M.D., and GEORGE F. HEWSON, M.D., St. Michael's Hospital, Newark, N. J.

The purpose of this report is to add to the literature, which contains few examples, another clinically-proven case of traumatic fat embolism, with complete recovery. J. C. Whitaker,¹ in a recent publication, presented two recovered cases, and asserted that only one other case could be found in the American literature. Usually either most patients with fat embolism recover without a diagnosis being made; or else a post-mortem examination reveals the true pathology. A comprehensive discussion of the subject will not be attempted here, and the reader is referred to the excellent monographs of Warthin,² Landois,³ Vance⁴ and Wright.⁵

REPORT OF A CASE

E. C., an eighteen-year-old student, was admitted to St. Michael's Hospital, Newark, N. J., on October 6, 1939. He had always been in good health, and an hour before admission, he was injured in a school football game. He complained of severe pain in the left leg. He could not rise, and was transported to the hospital on a stretcher.

Physical examination revealed a swollen and tender left leg, with a moderate degree of deformity over the middle third. A diagnosis of fracture of the tibia and fibula was made, and this was confirmed by roentgenograms. His leg was immediately immobilized by means of a posterior non-padded plaster splint. On admission his temperature was 100, pulse 85, respirations 22, urine negative, and complete blood count normal.

Eighteen hours after being admitted, the patient became restless, developed pain in the chest, became dyspneic and moderately cyanotic, and started to

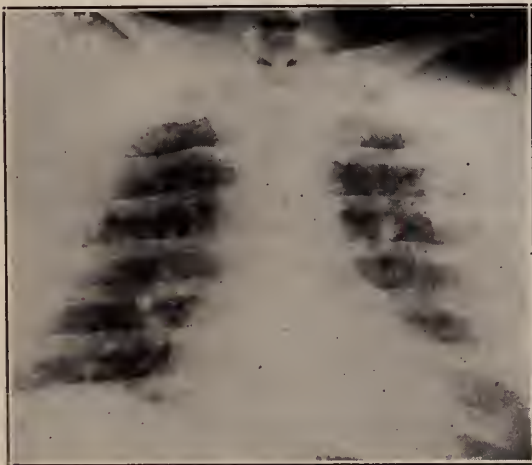


FIGURE 1

Portable x-ray of lungs on October 9, 1939, three days after injury, reveals diffuse mottling bilaterally,—representing pulmonary fat embolization.

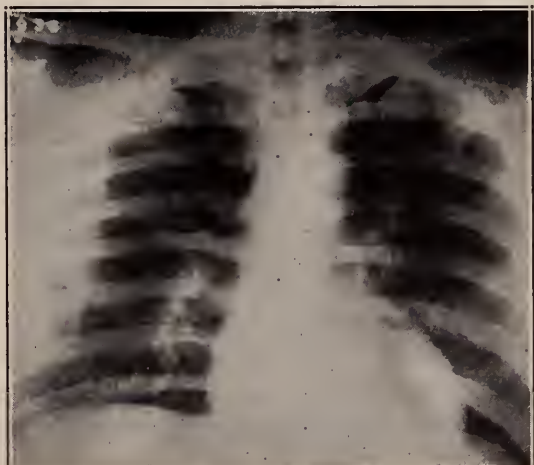


FIGURE 2

X-ray of lungs on November 13, 1939, when patient was clinically well, is essentially clear.

cough up some frothy blood-streaked sputum. His temperature rose to 103, and the pulse to 115. At times he exhibited frank hemoptysis. Physical findings were confined to the chest, where medium inspiratory râles could be detected bilaterally, both front and back. These findings were persistent over the several days that his temperature continued at 103. Sulfapyridine was at first instituted because of the initial diagnosis of diffuse bronchopneumonia; but it was discontinued after twenty-four hours of administration. The treatment was chiefly palliative, and included oxygen therapy, sedation, and intravenous glucose injections. There was a gradual improvement in the patient's condition, and the temperature took about eighteen days to slowly flatten out to normal. At this time the patient felt well, and no chest findings were present.

LABORATORY DATA

Sputum studies on October 10 and 12 revealed no pneumococci. Fat globules were positively identified in the sputum on October 11, and October 14. Some fat globules were recognized in the urine on October 11, but could not be found thereafter. Blood counts were all within normal range. Blood cultures were negative on several occasions. X-rays of the chest were particularly interesting. The film taken October 9 (see figure 1) showed diffuse bilateral mottling of the lungs. Serial x-rays showed gradual clearing. The last film, taken November 13, was clear (see figure 2).

Although recovery from traumatic fat embolism was complete, a severe infection of the left leg necessitated amputation on December 7, 1939.

COMMENT

This case presented the *pulmonary* form of traumatic fat embolism, in contradistinction to the *systemic* types, where certain nervous system lesions predominate. The relationship to trauma, the signs and symptoms, the radiological studies of the lungs, the identification of fat globules in the sputum and on one occasion in the urine clinically, established a defi-

nite diagnosis. The chest x-rays seem quite characteristic, and attention can be drawn to the experimental studies of F. Jirka and C. Scuderi.⁶ It is well to conclude that a diagnosis of traumatic fat embolism can be made clinically with reasonable facility where this condition is kept in mind; and that cases, even moderately severe, may recover completely.

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DIGESTIVE DISTURBANCES IN THE HEMORRHAGIC DISEASES

By THOMAS FITZ-HUGH, JR., M.D., Philadelphia, Pa.

From the Hematology Section of the Medical Clinic, Hospital of the University of Pennsylvania. Read before the Section on Gastro-enterology of the Annual Meeting of The Medical Society of New Jersey in Atlantic City, June 5, 1940.

The intimate relationship of gastroenterology and hematology has long been recognized. A little more than ten years ago this liaison was immeasurably strengthened by the brilliant experiments of William Castle which established the fact that pernicious anemia is fundamentally a deficiency disease, conditioned by gastric malfunction. Thus was conceived and brought forth a new idea in medicine—the *conditioned deficiency hypothesis*—which has proven so fruitful not only for pernicious anemia, but also for other hitherto obscure deficiency states.

Lying largely within, but extending beyond, the limits of classical hematology is a hetero-

genous group of disorders which are characterized by abnormal bleeding. My assignment is a summary of the gastrointestinal and digestive disturbances encountered in patients presenting one form or another of the hemorrhagic diathesis.

THE MALIGNANT LYMPHOMATA

The leukemias, lymphosarcoma, leukosarcoma, and Hodgkin's disease, while not predominantly hemorrhagic, may cause abnormal bleeding at some stage in most patients. The mechanism of hemorrhage in these diseases may be thrombocytopenic (as in acute leukemia and acute or terminal phases of chronic leu-

kemia); thrombotic and ulcerative as in any local malignancy; or the result of capillary damage and hepatic infiltration. Bleeding from tooth extraction and cerebral apoplexy are the most common initial hemorrhagic accidents encountered in the chronic leukemias; whereas purpura is the most common in the acute cases.

The gastrointestinal disturbances in these malignant states are not specific except in so far as splenic and hepatic infiltrations are the rule; and stomatitis is almost universal in acute phases. Sometimes local neoplastic mucosal lesions of the gastrointestinal tract are encountered which may produce pain, obstruction or hemorrhage simulating carcinoma both clinically and roentgenologically. Approximately 40 per cent of leukemics are achlorhydric. Jaundice and ascites may occur late in these diseases.

POLYCYTHEMIA VERA

Bleeding gums, and abnormal bleeding from tooth extraction, are not infrequent in polycythemia. But more serious and more common are the episodes of *thrombosis* which may occur anywhere in the vascular channels. The mechanism of hemorrhage here is primarily thrombotic, and due to capillary engorgement, stasis, high viscosity, thrombocythemia, and obliterative endarteritis.

Peptic ulcer is not uncommon in patients suffering from polycythemia vera. Infarcts of the liver, spleen, and mesenteries (from arterial thrombosis) are common. Such catastrophies may be survived several times by a given individual, although they, together with cerebral thrombosis, constitute the most common mode of death.

PERNICIOUS ANEMIA

The markedly reduced platelet content characteristic of severe hematologic relapse in pernicious anemia may cause such hemorrhagic phenomena as purpura, epistaxis, hematemesis, melena, and metrorrhagia.

The gastrointestinal disturbances of pernicious anemia, from glossitis, through gastritis and colitis to proctitis, are too well known to require further comment. The simulation of gastric carcinoma by pernicious anemia is also

an old story. The occurrence of both diseases in the same patient is more common now than formerly, due to the life-preserving effects of liver therapy, and to the common denominator of achylic gastritis which may predispose to both.

HEMOPHILIA

The outstanding hemorrhagic disease, hemophilia, presents no symptoms of gastroenterologic interest, except when abdominal visceral trauma is unhappily encountered, or when one of these unfortunates develops an abdominal lesion generally considered surgical. From the gastroenterologic viewpoint, it is interesting to note that a really black stool requires about 80 c.c. of swallowed blood for its production.

HEMORRHAGIC DIATHESIS OF THE NEW BORN

The mechanism of hemorrhages in melena neonatorum is now generally believed to be a matter of *prothrombin* deficiency. Its successful management by vitamin K therapy, and transfusion will be discussed, together with other therapeutic matters, at the end of this summary.

THE HEMORRHAGIC PURPURAS

Welhof's purpura hemorrhagic (thrombocytopenic) is caused by under-production or over-destruction of the blood platelets, and by capillary damage with resulting hemorrhages of all kinds.

Allergic and anaphylactoid purpuras, including the so-called Henoch's purpura, are sometimes mediated by thrombocytopenia, and sometimes by capillary damage with normal platelet content.

The gastroenterologic phenomena of these diseases include melena, hematemesis, and abdominal pain from subperitoneal hematoma and hemoperitoneum. All of this may disastrously simulate the acute surgical abdomen. In such cases of purpura, the clinician should search for possible allergic clues, especially evidence of gastrointestinal and cutaneous food allergies, and drug idiosyncrasies. However, in some instances of acute or chronic thrombocytopenic purpura, casual infection seems to be the precipitating factor, in others estrogenic

disturbances, and in some no adequate explanation can be found.

CHRONIC OBSTRUCTIVE JAUNDICE

The mechanism of the hemorrhagic diathesis of obstructive jaundice now stands revealed as a conditioned deficiency. In the absence of bile from the gastrointestinal tract, the fat soluble vitamin K of normal food is not absorbed, and the liver thus loses an essential precursor of the prothrombin necessary for normal coagulation.

The gastroenterologic disturbances in this type of hemorrhagic diathesis vary with the cause of the biliary obstruction. A history suggestive of gall-stone disease is common. Other causes such as hepatic cirrhosis, abdominal carcinoma with hepatic metastasis, and pancreatic carcinoma, must be considered. A sometimes confusing state of affairs is occasionally encountered in hemolytic icterioanemia and sickle cell anemia when the characteristic hemolytic icterus becomes complicated by calculous obstruction of the common duct with consequent superaddition of profound obstructive jaundice.

ILLUSTRATIVE CASE

A lad of fifteen was referred recently because the family physician was unwilling to accept the diagnosis and hopeless prognosis given elsewhere of progressive terminal juvenile biliary cirrhosis. On examination this boy was found to be deeply jaundiced, with white stools, mahogany-colored urine, fever, abdominal distress, vomiting, purpuric bleeding, and ominous drowsiness of two weeks' duration. There was a mass in the right upper quadrant and the spleen was considerably enlarged.

Questioning brought out the fact that, at five years of age, this boy had an attack of jaundice, and had not been "quite right" since. There were found slight anemia, an immediate direct van den Bergh reaction with an indirect reading of "over 40 units", reticulocytes of 10 per cent, typical spherocytosis, and a fragility test showing hemolysis beginning at .650 and complete at .425.

An x-ray film of the abdomen showed some calcified shadows in the right upper quadrant. A diagnosis was made of gall-stone obstruction of the common duct complicating chronic hemolytic icterioanemia.

After preparation with vitamin K and transfusions which brought the prothrombin time down from 128 seconds to 24 seconds, operation was performed (Dr. I. S. Ravdin). Stones were removed from the distended gall-bladder and common duct.

Some weeks later, after subsidence of jaundice, splenectomy was performed. This boy is now perfectly well.

SPLENIC ANEMIA AND BANTI'S DISEASE

The hemorrhagic phenomena here are generally the result of portal obstruction, or splenic vein thrombosis with consequent formation of varices in the esophageal, gastric, and anal veins. The gastrointestinal disturbances of this ill-defined group of disorders include hematemesis, melena, hepatic and splenic enlargement, splenic vein thrombosis, and finally jaundice and ascites.

ETIOLOGIC APPROACH TO THERAPY

In the hemorrhagic purpuras, a careful allergy survey is indicated, not only in respect to foods and industrial and bacterial allergens, but also with an eye to prior medication (especially sedormid, benzol, arsphenamines and bismuth).

In the hemorrhagic diathesis of biliary obstruction, the surgical removal, if possible, of the obstructing agent is of paramount importance.

Splenectomy is to be considered in Werlhoff's disease, splenic anemia, and early Banti's disease, and of course in hemolytic icterioanemia. If calculous obstruction of the common duct has supervened in a case of hemolytic icterioanemia, surgical drainage of the duct must precede splenectomy. In the presence of unobstructing cholelithiasis in these cases, however, splenectomy should precede, rather than follow, the elective operation of cholecystectomy.

Judicious roentgen ray therapy is the unsatisfactory best we have to offer for sufferers from the malignant lymphomata of chronic type. For the acute leukemias we have nothing curative to offer, despite all the unfortunate radio and press publicity concerning this tragic malady which seems to be on the increase, especially in childhood. This increase may be more seeming than real, however, due to better modern diagnosis.

In this connection it should be stressed that certain other disorders may simulate acute leukemia in the early stages, which no doubt

accounts for some of the alleged cures. Furthermore, patients with chronic leukemia, seen for the first time in an acute relapse, may be mistakenly diagnosed as acute leukemia. Chronic leukemics, under proper management, may "recover" from a number of relapses and may live useful normal lives for many years. I can testify personally to all of these points. I have two patients with chronic leukemia of twelve to fourteen years' duration who are alive, comfortable, and active.

Some years ago, before the advent of the heterophile antibody test, I saw a boy in consultation in whom I made a diagnosis of "probable acute leukemia", who later turned out to have a combination of simple iron deficiency anemia, plus acute infectious mononucleosis. He recovered completely.

Last year a lady whom I had treated (happily with successful outcome several years before) for agranulocytic angina caused by aminopyrine, presented herself in good faith to a certain broadcasting company as a cured case of leukemia, and offered her blood in the hope of helping a child with acute leukemia. She

gave my name as having cured her of leukemia so that when the broadcasting company wired me for confirmation I was able to prevent the well-intended but tragic farce in this particular instance.

Management of the deficiency states includes correction, when possible, of gastrointestinal and biliary conditioning factors, together with specific replacement, often parenterally, of the deficient factors. This means bile salt and vitamin K therapy in obstructive jaundice; hydrochloric acid and liver extract in pernicious anemia; vitamin C in scurvy; the generally advisable employment of high protein, high vitamin diets; and the judicious use of blood or plasma transfusions, which in these hemorrhagic conditions should be from freshly-bled donors.

The necessary surgery of chronic bile duct obstruction has now been rendered immeasurably safer by the newer knowledge of vitamin K therapy and bile therapy; and the pre- and post-operative attention to vital nutritional factors is adding and will add still more to better surgical and medical statistics.

SERUM AND CHEMOTHERAPY IN PNEUMONIA

1. A COMMUNICATION FROM DR. MAHAFFEY

To Physicians of New Jersey:

Since the advent of chemotherapy there has been a considerable decrease in the amount of specific serum used in the treatment of pneumonia. Undoubtedly, this is justifiable, due in a measure, to the efficiency of these new drugs. The prevalence of atypical rather than type specific pneumonias of the last two years may also be a factor.

In spite of this, however, many feel that to further reduce the mortality from pneumonia, more of the specific serum could be advantageously employed, both alone and in combination with chemotherapy. We are glad to

send you the enclosed recommendations sponsored by the Pneumonia Control Committee of the New Jersey State Medical Society.

Serum for use in treating cases of pneumonia of specific types, in persons financially unable to pay for the material is still furnished by the State through this Department, and is available at stations listed on the sheet sent you a short time ago. (Jour., August, 1938, page 513.)

Very truly yours,

J. LYNN MAHAFFEY, M.D.,
Director of Health.

February 21, 1941.

2. A COMMUNICATION FROM THE COMMITTEE ON PNEUMONIA CONTROL

INDICATIONS FOR THE USE OF SERUM AND CHEMOTHERAPY IN THE TREATMENT OF PNEUMONIA

Since the effectiveness of chemotherapy in the treatment of pneumonia has been established, we feel that there has been an unproportional decrease in the amount of specific serum used in this disease. This, we believe, is not in keeping with the best medical practice.

Accordingly, the Pneumonia Committee of the New Jersey Medical Society offers the following modified scheme of Maxwell Finland as a guide for the choice of therapy; and emphasizes that specific serum has its place in the treatment of this disease both alone and in combination with chemotherapy.

Chemotherapy should be used alone and serum avoided, if possible, in the following conditions:

1. Patients with a strong history of asthma or other allergic manifestations; and particularly those who are specifically sensitive to the animal serum available, or to the emanations of that animal.

2. Patients who have been treated with serum from the same animal source within a few months.

3. Patients who are in extremis, or have definite evidence of cardiac or peripheral failure. Such cases may receive serum later, if necessary, when these conditions have yielded to therapy, and preferably after chemotherapy has been given.

4. Patients showing obvious improvement after 18 to 24 hours of chemotherapy.

5. Patients with multiple types of pneumococci should be given chemotherapy first, and serum later, if necessary, except when one of the organisms is of Type I or II. It is in these types that serum has proven itself most efficacious.

Chemotherapy and serum should be used under the following conditions:

1. When chemotherapy has been given in the usual doses for 18 to 24 hours without obvious improvement.

2. In patients over 40 years of age.

3. In pneumonias complicating pregnancy or the puerperium.

4. When more than one lobe is involved.

5. When pneumococcus bacteremia is known to be present.

6. In all cases due to Type III pneumococcus. In such cases it may be advisable to delay serum treatment until 8 to 18 hours after the first dose of the drug.

7. In severe cases when treatment is begun after the third day.

8. When the administration of the drug is accompanied by marked nausea and vomiting, or other serious toxic effects.

Serum should be used alone and chemotherapy should be avoided, if possible, under the following conditions:

1. In patients with leucopenia, with a low proportion of polynuclear cells.

2. In the presence of severe anemia.

3. In the presence of jaundice.

4. When there is impaired renal functions.

5. In post-operative cases, especially after abdominal operations.

6. In patients who have received chemotherapy and have been known to have a resulting drug rash, leucopenia, anemia, or jaundice.

7. In cases diagnosed during the first two or three days, the use of serum alone may be advantageous because of the striking and rapid beneficial effect, and because the toxic effects of the drug can be avoided.

Serum treatment should be discontinued in those who have had a severe shock-like reaction, and asthmatic attack, or urticaria, or alarming thermal reactions following the injection.

Chemotherapy should be discontinued for rapidly developing anemia, jaundice, hemoglobinuria, hematuria, leucopenia, nitrogen retention, edema, drug rash, marked overexcitement, intractable vomiting, or failure to obtain obvious clinical improvements after 36 to 48 hours, provided that serum has not been given and focal complications are not present.

Dr. Russell L. Cecil summarizes it very aptly: " * * * We have a double-barreled gun for the treatment of pneumonia, and whether we need both barrels or only one remains to be seen. Dr. Bullowa and Dr. MacLeod expressed it very well when they said that serum fortifies the pneumonia patient; sulfapyridine injures the pneumococcus. For the present we must keep our serum handy, and use it along with sulfapyridine; and we must continue to type our pneumonias in order that we must get all the better oriented with regard to this new form of therapy."

Certainly specific serum so gratuitously supplied by the State maintains its prestige along with chemotherapy; and we urge its continued employment in the war on the pneumococcus.

Pneumonia Control Committee of the
New Jersey State Medical Society.

RECOMMENDATIONS FOR THE CARE OF PREMATURE INFANTS

MATERNAL WELFARE ARTICLE NUMBER FIFTY-SEVEN

Prepared by the

Child Welfare Committee of the Essex County Medical Society; Child Health Committee of The Medical Society of New Jersey; Maternal Welfare Committee of the Essex County Medical Society; Maternal Health Committee of The Medical Society of New Jersey; Hospitals Committee of the Essex County Medical Society.

1. That hospitals caring for premature babies have a premature service.
2. That ward cases should be assigned at birth to the premature service.
3. That early consultations with a competent pediatrician should be urged for private cases.
4. That the premature baby should be treated as an emergency. When a premature birth is expected, the premature service should be notified in advance.
5. An approved list of hospitals recognized as premature centers after requirements have been fulfilled, will be set up.
6. Hospitals having twenty-five or more premature births per year should have special rooms; all others should be able to give isolation care when needed.
7. Each hospital should have an adequate number of incubators or heated beds, with temperature control.
8. Heated beds should be available at the Bureau of Maternal and Child Health for distribution where needed temporarily, or where hospital care is not available.
9. Oxygen should be readily available, and also adequate means for controlling oxygen supply and feed in an enclosed space.
10. An incubator or heated bed should always be available in delivery room, and transportation to premature room or nursery should preferably be in an incubator or heated bed, warmth to be maintained in transit.
11. Methods should be considered for transporting premature babies to hospitals giving adequate care.
12. Premature ambulances should be made available by the Bureau of Maternal and Child Health of the State Department of Health, where more urgent need exists.
13. Premature births outside of hospitals should be reported to the Board of Health.
14. Three, or at least two, nurses specially trained in the care of premature babies should always be available in premature centers. Recommendation is made that the Bureau of Maternal and Child Health of the State Department of Health, assist hospitals in providing for educating nurses in this field.
15. That a State Medical Society Joint Committee composed of members of the Maternal, Child Health, and Hospitals Committees be appointed to examine plans of hospitals when new maternity floors and new nurseries are being built, or changes contemplated.
16. That the plans for the better care of premature babies in New Jersey be carried out in coöperation and conjunction with the Bureau of Maternal and Child Health of the State Department of Health.

A LESSON FROM A DEATH CERTIFICATE

NUMBER TWENTY-NINE

Grav. ii, para i.
Asymetric pelvis, brow presentation.
Thirty-three hours in labor.
Cesarean.
Sepsis.
Death.

A. W. BINGHAM.

STATE SOCIETY ACTIVITIES

WELFARE COMMITTEE

A meeting of the Welfare Committee of The Medical Society of New Jersey was held on Sunday, February 9, 1941, 2:00 p. m., in the Carteret Club, Trenton, Dr. Hilton S. Read, Chairman, presiding. Those present were:

1. COUNTY REPRESENTATIVES

Atlantic

Hilton S. Read, Chm.	William J. Carrington
David B. Allman	Samuel Barbash

Bergen

G. Barton Barlow	Spencer T. Snedecor
Joseph R. Morrow	William K. Harryman

Burlington—Joseph M. Kuder

Camden

Reuben L. Sharp	Harold D. Barnshaw
Henry B. Decker	

Cape May—Clarence W. Way

Cumberland—Millard F. Sewall

Essex

Alfred Stahl, Secretary	Wright MacMillan
Arthur W. Bingham	H. Roy Van Ness
Harry N. Comando	Elbert S. Sherman
Julius Levy	Chester R. Brown
Frank Bien	Charles M. Robbins
Edgar P. Cardwell	

Gloucester

Wendell J. Burkett	Louis K. Collins
Chester I. Ulmer	

Hudson

Joseph F. Londrigan	F. J. Quigley
B. S. Pollak	A. C. Ruoff

Hunterdon—Samuel B. English

Mercer

D. Leo Haggerty	Charles H. Mitchell
Joseph E. Raycroft	

Middlesex

Jacob J. Mann	Henry Haywood
William C. Wilentz	

Monmouth

C. Byron Blaisdell	Robert E. Watkins
Stanley Nichols	

Morris—None

Ocean—J. Edwin Obert

Passaic—Sigurd W. Johnsen

Salem—C. Spencer Davison

Somerset—Frank L. Field

Sussex—None

Union

Watson B. Morris, Pres.	Frederic W. Lathrop
Herschel S. Murphy,	Norman W. Burritt
Vice-Chairman	James M. Carlisle

Warren—William H. Varney

2. ADVISORY

Mr. William H. MacDonald, State Department of Health

LeRoy A. Wilkes, Secretary of Committee

Frank Overton, Editor

Norman M. Scott and Mr. Joseph J. Harty, from the Medical Service Administration

3. TRUSTEES

Harry R. North	G. W. Fithian
Thomas K. Lewis	Samuel Alexander

4. GUESTS

H. B. Diverty	Emil Frankel
Henry A. Davidson	C. H. Schlichter
Otto M. Holters	J. C. Brown
A. W. Pigott	

GREETINGS FROM PRESIDENT MORRIS

Dr. Watson B. Morris, President, outlined the work of the State Society during the first half year of his administration, mentioning the following activities:

1. The State Preparedness Committee on War, and local emergencies.
2. The Medical Service Administration.
3. Official visits to County Societies.
4. Survey of the out-patient departments of hospitals.
5. The Fall Clinical Conference.
6. The ad-interim meeting of the House of Delegates.
7. The Somerset County scientific session.
8. The Post-Graduate Courses.
9. The Public Relations Committee.
10. Preparations for the celebration of the 175th Anniversary of the founding of the State Society.
11. The Workmen's Compensation Committee.
12. Committee on Industrial Health and Hygiene.
13. Medical Legislation.

MEDICAL PREPAREDNESS

Dr. Charles H. Schlichter, Chairman of the Medical Preparedness Committee, described the work of the State Committee, supplemented by the activities of a similar committee in each County Society. He outlined the work in three divisions:

1. The Selective Service and Induction Boards.
2. The A. M. A. Questionnaire of members regarding the kind of service each can render in the event of war.
3. A survey of the local facilities to meet grave emergencies, under the direction of the State Defense Council.

PUBLIC HEALTH COMMITTEE

Dr. Stanley Nichols, Chairman of the Subcommittee on Public Health, introduced a resolution calling upon the Federal Government to appoint representatives of the medical profession and allied health organizations on the mission to England.

In the Report of the Public Health Committee to the Welfare Committee, Dr. Nichols stated that the inescapable conclusion from the five items, to which he called attention, is that a definite plan for public health and medical care is being developed, to be presented as a part of national defense. He advised the Society to continue its studies, and plan to provide widespread medical services of good quality, and to see that anyone, who for any legitimate reason is not now receiving medical services, is provided with the opportunity to obtain them.

PUBLIC RELATIONS COMMITTEE

Dr. Charles M. Robbins, Chairman of the Subcommittee on Public Relations, reported that the committee had emphasized "Public Relations", or the promotion of a popular knowledge of the leadership of the medical profession in all medical matters, rather than "Health Education", or the broadcasting of concrete information on hygienic topics, such as cancer, and tuberculosis, and diabetes. Dr. Robbins gave a description of the work of the committee along the following lines:

1. Press publicity and a clipping service.
2. Coöperation with the Woman's Auxiliary.
3. Conducting a central bureau of registry of material available for popular health lectures.
4. Coöperation with lay health agencies.
5. The preparation of material for popular health exhibits.
6. Press releases on the Fall Clinical Conference.
7. Promotion of popular attention to the A. M. A. radio programs.

In every possible way the committee has informed the public regarding the public health aspects of the activities of the several departments of the State Society and its component County Societies.

MEDICAL PRACTICE COMMITTEE

Dr. Reuben L. Sharp, Chairman of the Subcommittee on Medical Practice, outlined the work of the Committee and its Advisory Committees, particularly the New Jersey Formulary, the model plan for conducting auxiliary

medical services in hospitals, and studies on the medical care of the indigent, and improvements in the Workmen's Compensation laws and procedures.

LEGISLATIVE COMMITTEE

Dr. Burkett, Vice-Chairman of the Subcommittee on Legislation, reported that the Committee was making progress in establishing contacts with members of the Legislature.

Dr. F. J. Quigley, Executive Secretary to the Legislative Committee, outlined a new definition of chiropody, and the Welfare Committee approved the introduction of this amendment to the Chiropody Act.

MEDICAL SERVICE ADMINISTRATION

Dr. Norman M. Scott, Medical Director of the Medical Service Administration, described the progress made in formulating the principles of its operation.

THE ANNUAL MEETING

Dr. J. Carlisle Brown, Chairman of the Standing Committee on the Annual Meeting, announced that no meetings of the sections would be held during the Annual Meeting; but at 2 p. m. on Tuesday a symposium on "Acute Abdominal Diseases" would be conducted, and at 10 a. m. on Wednesday morning, a general anniversary meeting will be held, at which representatives of the several health agencies will describe their work and will conduct an exhibit of their activities.

At 2:30 p. m. on Wednesday, there will be a symposium on "Peripheral Vascular Diseases".

CANCER CONTROL

Dr. Holters, Vice-Chairman of the Cancer Control Committee, at the request of the Chairman of the Public Health Committee, presented four motions which had been approved by the Public Health Committee.

1. To make cancer a reportable disease in New Jersey.
2. To endorse the recommendation that the State Department of Health provide additional staff personnel qualified to undertake field studies as to the etiological factors of cancer.
3. To endorse the work of the Curie Institute and the American Society for the Control of Cancer in their respective fields, where they were approved locally by the County Medical Society.
4. To endorse a proposed redistribution of funds collected in New Jersey by the Woman's Field Army of the American Society for the

Control of Cancer, for the purpose of retaining in New Jersey an increasing amount and reducing the amount sent to the national organization.

These motions were adopted.

WORKMEN'S COMPENSATION

The Welfare Committee approved a motion by Dr. Harryman, Chairman of the Workmen's Compensation Committee, that the revision of the Workmen's Compensation Act, concerning expenses allowable for hernia cases, be approved and given to the Legislative Committee for introduction into the Legislature.

FOOD AND DRUG ACT

The proposed amendment to the Food and Drug Act requiring additional recording of drugs dispensed by physicians, for their own protection, was referred to the Committee on Pharmaceutical Problems and the Committee on Legislation for joint action.

Editorial Comment—The reports given by the officers and committees were along the lines to be described in detail in their annual reports which they will soon begin to formulate. Judging by the outlines that were presented before the Welfare Committee, the annual reports to be published in the May Journal will be unusually comprehensive and informative.

MEDICAL SERVICE ADMINISTRATION OF NEW JERSEY

A PROJECT OF THE MEDICAL SOCIETY OF NEW JERSEY

Medical Service Administration is organized on a *county* basis. It will be administered and coördinated on a *State* basis. This is in accordance with our Enabling Act.

COUNTY PARTICIPATION

Medical Service Administration has been formally presented to each of the component county societies. By vote of its members, each county society has approved the objectives of the Administration.

To comply with our Enabling Act, requiring organization on a county basis, we must receive signed agreements of participation from 51 per cent of all physicians residing in each county. The Administration cannot operate in any county in which less than 51 per cent of physicians are participants.

As of March 1, the following counties have qualified for participation:

Cape May	Gloucester	Ocean	Sussex
Essex	Mercer	Salem	Warren

The status of the remaining counties is as follows:

County	Physicians Participating
Atlantic	35 per cent
Bergen	33
Burlington	45
Camden	17
Cumberland	7
Hudson	20
Hunterdon	30
Middlesex	17
Monmouth	17
Morris	33

Passaic	19
Somerset	45
Union	11

EFFECT ON THE PHYSICIAN

The most frequent question asked by physicians is, "How will it affect my practice?"

Participation should have no deleterious effect upon the private practice of any physician. It should have a beneficial effect.

Beneficiaries are guaranteed free choice of physician from among the participating physicians, thus retaining a principle of the competitive practice of medicine. The State applies this principle in a practical way by requiring that 51 per cent of physicians in any county be participants.

The physician is protected by the *statute*, which states that services of physicians shall be "in accordance with the accepted practices in the community".

He is further protected by the supervisory power of the *Board of Trustees* of The Medical Society of New Jersey, and by the physicians who are members of the Board of Governors of the Administration. On a county basis the interests of the physicians will be protected by the *County Advisory Committee* appointed by each county medical society.

FEE SCHEDULE

The Administration will have no fixed fee schedule, for there is no authoritative fee schedule pertaining to private practice in New Jersey.

After deducting the necessary costs of ad-

ministration, all money received will be disbursed to pay physicians' fees.

Subscription rates have been adjusted to allow fees commensurate with the income class of subscribers. During the early months of operation, an abnormal demand for medical services may be expected. This will result in a reduction of fees per individual case; however, the gross income from the group will undoubtedly be equal to, or in excess of, the gross income now being received by physicians from this income class of patients. It has been the experience in other states that fees paid after the sixth month of operation are satisfactory to the profession.

THE AGREEMENT OF PARTICIPATING PHYSICIAN

The agreement which was inserted as a loose leaf in the February Journal was drawn up to assure the protection of the physician. It is an agreement between the physician and the eight men composing the Board of Governors of Medical Service Administration. Neither the subscriber, nor any other third party is concerned in the content of this agreement.

1. The first paragraph refers to our enabling act. This act limits the operation of medical service corporations in this State to those approved by the Board of Trustees of The Medical Society of New Jersey. It requires free choice of physician by demanding participation of at least 51 per cent of the physicians from each county. It demands that all participating physicians have a full license to practice medicine in New Jersey. It allows for free choice of patient by the physician "in accordance with accepted medical practices in the community". Hence, there is no interfer-

ence with the practice of the specialty, nor is there any other limitation imposed upon the type of practice you wish to follow. It prohibits the Administration from "imposing any restrictions upon physicians as to methods of diagnosis or treatment".

2. The second paragraph states that the physician will accept such compensation as shall be determined by the Board of Governors. This is a necessary provision, as we are unable to tell at this time what fees our subscription rates are capable of supporting. We believe the fees will be adequate. We have no previous fee schedule to guide us, as no fee schedule has ever been adopted by any county society.

3. The third paragraph allows for termination of this agreement at any time; but as we must guarantee participation of 51 per cent of physicians in existing contracts, your resignation will not be effective until the termination of such contracts as are in force on the day we receive your notice of resignation. During the remainder of that contract year, you still have free choice of patient from among those who apply to you for treatment.

The success of Medical Service Administration depends upon the coöperation of the profession. The future of the private practice of medicine may depend upon the united efforts now being made by medical service corporations throughout the United States. Every physician is urged to read the By-Laws, Rules, and Regulations of the Administration, and to give time to the study of the problems. It is felt that, if physicians understand the problems, they will willingly participate in the effort being made by the State Society.

MEDICAL PREPAREDNESS

A meeting of the Committee on Medical Preparedness of The Medical Society of New Jersey, Chairmen of County Committees, and representatives of induction and local boards was held at the Carteret Club on Sunday, February 9, 1941, at 11 a. m. The following were present: Dr. Charles H. Schlichter, Chairman; Drs. F. P. Guidotti, H. D. Corbusier, J. J. Mann, John H. Rowland, R. M. Nittoli, H. Roy Van Ness, W. W. Pedrick, S. A. Cosgrove, William J. Carrington, B. C. McMahon, William H. Jamison, F. R. Sheppard, A. S. Hulett, D. B. Allman, T. K. Lewis, H. B.

Decker, S. T. Snedecor, Alfred Stahl, W. B. Morris, and N. M. Scott, Secretary.

1. CHEST X-RAYS

Dr. Schlichter reported on the concert of action between the Second Corps Area of the Army and the New Jersey State Tuberculosis Committee, so that every man inducted into the service received an x-ray examination of his chest at a cost of 75 cents per man, the cost being paid by the Federal Government.

2. REJECTIONS

Dr. Scott gave a summary of the rejections reported by the Induction Boards as follows:

2 A. REJECTIONS BY INDUCTION BOARDS, FOR ALL CAUSES

November 25, 1940, to January 31, 1941

a. Number Selectees examined	6255	White, 28	Colored, 6283	Total
b. Number rejected, medical causes	969	White, 7	Colored, 976	Total
c. Number rejected, non-medical causes	46	White,		46 Total
d. Total rejections	1015	White, 7	Colored, 1022	Total
e. Total number inducted	5237	White, 21	Colored, 5258	Total

(There is an error of three (3) in the above totals, due to two (2) previous mistakes which cannot be corrected in this office.)

f. Percentage of rejections	Total—16.2
Percentage of rejections for medical causes	15.5

(See the report in The Journal, February, 1941, page 96.)

2 B. REJECTIONS BY INDUCTION BOARDS FOR TUBERCULOSIS ONLY

The following table shows the number of rejections by the Induction Boards for tuberculosis only, from November 23, 1940, to February 28, 1941:

Total selectees examined	12,016
Number selectees x-rayed	11,873*
Number rejected for tuberculosis	80
Percentage rejected for pulmonary tuberculosis	0.67

Under 2 C of this paragraph we report the cases of tuberculosis found by the 202 Local Boards.

*Aliens and those with criminal records were not x-rayed.

2 C. REJECTIONS BY LOCAL BOARDS

The following table is the statistical report of registrants physically examined by the 202 local boards, up to December 31, 1940:

Total number of registrants examined	16,412
Percentage classified in 1-A (fit for full military service)	53.92
Percentage classified in 1-B (approved for limited service)	16.7
Percentage classified in 4-F (unfit for military service)	25.51
Percentage of examined registrants who were referred to the ten Medical Advisory Boards for consultation	9.12
Number of pulmonary tuberculosis cases found by local boards	139
70 were previously unknown.	
69 had been previously reported in civilian life.	

There has been a dramatic improvement in the work of the Local Boards, due to a more thorough understanding and better interpretation of the regulations. This has resulted in a rapid fall in the rate of rejections by the Induction Boards. The general rate of rejections by Induction Boards up to January 31 was 16.2 per cent. This has been reduced during the month of February to 10 per cent. During one examination day, the rate of rejection in one Board was only 1.7 per cent of men examined. These results must be credited to the excellent work now being done by the members of the Local Boards, as a result of their increasing experience.

3. REHABILITATION OF REJECTED MEN

On motion of Dr. Lewis the committee approved a suggestion that the Medical Society coöperate with the State Rehabilitation Commission in formulating a plan for correcting the defects of men rejected in the draft.

4. FIRST AID AGENCIES

In response to a request from the State Police, Dr. Schlichter presented a form of certificate to be issued to civilian members of first aid squads, certifying their ability to give first aid intelligently and safely. The committee approved the certificate, and also a suggestion that examinations and tests of the members of the squads be held periodically.

5. LIABILITY OF EXAMINING PHYSICIANS

The committee also discussed the question of the liability of members of examining boards for alleged malpractice in the course of a required examination, such as the removal of wax from the ear. It was the opinion of the committee that the question of the liability of a medical examiner be referred to the Adjutant General, and also the Attorney General, for a legal opinion.

6. OFFICIAL REPORT

The Newark Evening News of February 20, 1941, contains the following quotation from the report of Lieutenant Colonel Azoy to Colonel Magruder, who is in charge of recruiting in the Second Corps Area:

"The procedure of routing selectees through the Induction Station is especially well planned, and functions with complete smoothness and efficiency. Special mention should be made of the civilian medical team which is composed of high-class specialists who evince keen appreciation of the seriousness of their work."

7. NATIONAL CONFERENCES

On February 15, a representative of the State Medical Preparedness Committee attended a joint conference on Medical Preparedness, held in the A. M. A. Building in Chicago, Illinois.

8. A. M. A. PREPAREDNESS QUESTIONNAIRE

There have been three distributions of the A. M. A. preparedness questionnaire to the physician of New Jersey. There remain about 1150 physicians who have not returned their personal reply. On March 1, the names of all delinquents were referred to the respective county societies for personal contact.

The majority of delinquents are non-members of a county society, or are physicians holding a license in this State but not in active practice.

It is very important that every physician be accounted for, in order that the potential professional facilities of this State may be properly interpreted by the War Department. Every member of The Medical Society of New Jersey is requested to cooperate in obtaining 100 per cent returns from this State.

On February 16 he attended the Conference on Medical Service, held in the Palmer House, Chicago, at which 250 physicians discussed subjects connected with medical preparedness and medical economics. (A similar meeting held in 1940 is described in this Journal, January, 1940, page 38, and March, page 118.)

CHARLES H. SCHLICHTER, M.D.,
Chairman.

GRADUATE COURSE IN TUBERCULOSIS

The Medical Society of New Jersey announces a Post-Graduate Course in Pulmonary Tuberculosis at the Hudson County Tuberculosis Hospital, 100 Clifton Place, Jersey City, N. J., April 4, 1941, to April 25, inclusive.

This course is arranged by the Advisory Committee on Tuberculosis, in cooperation with the Committee on Post-Graduate Education.

This course has been arranged at the request of the Sub-Committee on Public Health of The Medical Society of New Jersey, by the Advisory Committee on Tuberculosis, in conjunction with the Committee on Post-Graduate Education of the State Society.

The course will consist of seven lectures to be given on Monday and Friday afternoons, from three until five o'clock, beginning April 4th and ending April 25th.

All lectures and demonstrations will be given at The Hudson County Tuberculosis Hospital by various members of the staff. A part of each session will be devoted to questions and round-table discussion.

The course is open to practicing physicians

from any part of the State. Applications should be accompanied by a fee of \$5.00, and sent to the office of Dr. B. S. Pollak, Medical Director, The Hudson County Tuberculosis Hospital, 100 Clifton Place, Jersey City, N. J.

Internes and nurses will be admitted free.

OUTLINE OF COURSE

Friday, April 4th—Introduction, B. S. Pollak, M.D.
Pathogenesis of Pulmonary Tuberculosis, I. Earle Gerber, M.D.

Monday, April 7th—Bacteriology and Immunity in Tuberculosis, I. Earle Gerber, M.D.

Friday, April 11th—Clinical Classification of Pulmonary Tuberculosis, Camuel Cohen, M.D.

Monday, April 14th—Case-Finding: The Role of the Physician and the Clinic (Demonstration of Tuberculin-Testing), Abraham E. Jaffin, M.D.

Friday, April 18th—Interpretation of Fluoroscopic and X-Ray Findings in Pulmonary Tuberculosis, Harry J. Perlberg, M.D.

Monday, April 21st—Medical Treatment of Pulmonary Tuberculosis, Benjamin P. Potter, M.D.

Friday, April 25th—Surgical Treatment of Pulmonary Tuberculosis, Frank Bortone, M.D.

ADVISORY COMMITTEE ON CANCER CONTROL

A meeting of the Advisory Committee on Cancer Control was held on Thursday, January 23, 1941, 8:30 p. m., at the home of Dr. Edgar A. Ill, 449 Highland Avenue, Newark, N. J. Those present were: Dr. Edgar A. Ill, Chairman, and Drs. L. S. Snegireff, O. R. Holters, W. G. Herrman, W. O. Wuester, P. S. Avery, and W. B. Morris.

It was voted to request the State Department of Health to supply a statistician on full time to register and follow up all cancer cases.

It was also voted to invite the representatives of the Curie Institute and the American Society for the Control of Cancer to a dinner meeting with the Cancer Control Committee of the State Medical Society in the near future.

REQUEST FOR INFORMATION

At its meeting on October 25, 1940, the Cancer Committee requested each of the two state-wide organizations engaged in cancer control to submit detailed information regarding its program, its methods, and its finances (Jour., Dec., 1940, page 608). In response to this request each of the two organizations submitted a detailed report of its objectives and activities.

1. REPORT BY THE CURIE INSTITUTE

The report of the Curie Institute fills eight, single-spaced, typed pages. It is an endowed organization whose object is to provide facili-

ties for the diagnosis and treatment of cancer cases in the State of New Jersey. It plans to establish a small cancer hospital for research and study, and for providing radium for low-income patients. It will also provide facilities for training qualified physicians in the use of radium and deep x-ray treatments.

The Institute is pledged to seek the coöperation of all physicians and dentists in New Jersey. It also will form local chapters of the Institute.

2. REPORT OF THE NEW JERSEY STATE CANCER COMMITTEE

The New Jersey State Cancer Committee is a branch of the American Society for the Control of Cancer, Inc. It supplied detailed answers to the three specific questions submitted to it by the Cancer Control Committee of The Medical Society of New Jersey.

The New Jersey branch plans to conduct an educational campaign, and to distribute information supplied by the national organization.

The committee proposes to organize a *Field Army* in each county, which will conduct educational campaigns. It will also raise funds, 70 per cent of which will be expended locally. It will dispense the information through newspaper articles, public meetings, and the distribution of literature.

The committee submitted a financial statement showing the money received and the purposes for which it was expended.

RECORD OF DRUGS DISPENSED

The Journal of August, 1940, page 411, contained an article prepared by Dr. Robert P. Fischelis, Secretary of the Board of Pharmacy, and Dr. Chester I. Ulmer, Chairman of the Committee on Pharmaceutical Problems of the State Medical Society, setting forth the rules of the Food and Drug Law for dispensing drugs. The interpretation of the law of dispensing has been somewhat changed as the result of a legal opinion rendered by the Attorney General. The general principles of the law are as follows:

1. The containers in which drugs (except narcotics and hypnotics) are dispensed by a physician, shall bear the name and address of the physician, and directions for the use of the medicine.

2. Narcotics and hypnotics prescribed by

the physician or dispensed by him, come under special provision of the law:

A. Narcotics—Section 24:18-25.

B. Hypnotics—Section 45:14-23, and 45:14-24.

A physician dispensing either narcotics or hypnotics must keep a record of all such drugs which he has in his possession; and also of all that he dispenses; and the names and addresses of those to whom he dispenses the drugs. He shall display his records and stock to the official State Inspectors who request to see them.

The provisions in a proposed amendment are intended for the protection of the physician as well as his patient; but all physicians should, and most physicians do, as a matter of office routine, keep a record of all drugs dispensed and the directions given for their use in each individual case.

ANALGESIC MEDICATION

FROM THE COMMITTEE ON PHARMACEUTICAL PROBLEMS

CHESTER I. ULMER, M.D., Chairman, Gibbstown, N. J.

The constant use of proprietary analgesics by the public has become a menace to the health of the people. No physician wisely recommends analgesic compounds by name to the patient. In every instance in which he does this, he starts a chain of circumstances—namely, use of this preparation by the patient and all his friends and family.

Each illness is an entity in itself, requiring particular medication for the individual patient, based on his illness, and his age, weight, and personal idiosyncrasies, all of which the physician knows. Therefore, the wise physician individualizes his medication. Only the written prescription will do this.

During the Winter prevalence of colds, grippe, influenza, and sinus infections, the symptoms are often treated with analgesic prescriptions. Most of them contain acetylsalicylic acid or aspirin. The public takes it in large doses, and often smaller doses with the addition of acetphenetidin or phenacetin so that a synergistic action may be obtained, and the analgesic and antipyretic effect increased.

Here are several N. J. F. compounds:

CAPSULAE ACETANILIDI COMPOSITAE

℞	<i>Metric</i>	<i>Apoth.</i>
Acetanilidi	4.0 Gm.	3 i
Acid. Acetylsalicylici	4.0 Gm.	3 i
Sod. Bromidi	6.0 Gm.	3 iss.
Sod. Citratis	2.6 Gm.	gr. xlv
Ft. cap. no. xx.		
Sig: One capsule with a glass of water. Repeat in an hour if necessary.		

CAPSULAE ACIDI ACETYSALICYLICI COMP.

℞	<i>Metric</i>	<i>Apoth.</i>
Acidi Acetylsalicylici	3.25 Gm.	gr. L
Acetphenetidini	3.25 Gm.	gr. L
Caffeinae	0.65 Gm.	gr. X
Ft. cap. no. xx.		
Sig: One or two capsules as directed.		

These may be prescribed by name, as above; but the committee feels that a much better procedure would be to give individual prescriptions based on each patient's requirements.

Save your patient's money on the cost of medication by using U. S. P. preparations, and maintain the better respect of the patient.

Committee on Pharmaceutical Problems
CHESTER I. ULMER, M.D., Chairman
REEVE L. BALLINGER, M.D.
IRVING OKIN, M.D.
JACOB J. MANN, M.D.
DANIEL W. TELLER, M.D.

AMERICAN COLLEGE OF SURGEONS SECTIONAL MEETING IN PITTSBURGH

March 17, 18 and 19 have been set as the dates for a Sectional Meeting of the American College of Surgeons in which the States of Pennsylvania, Ohio, Virginia, West Virginia, Delaware, Maryland, New Jersey, and New York, and the District of Columbia will participate. Headquarters will be at the William Penn Hotel, in Pittsburgh. The twenty-one approved hospitals of Pittsburgh will provide an excellent clinical background for the College meeting. There will also be demonstrations of hospital procedures for the hospital executives' conference.

At the headquarters hotel there will be educational and scientific exhibits; and a showing of motion pictures portraying surgical and hospital procedures. A large public meeting on

the subject of "Conservation of Health" on the evening of the third day will be the final feature. Twenty-five subjects are listed for panel discussions.

The medical profession at large, and also hospital trustees, superintendents, pathologists, dietitians, and other hospital executive personnel are invited to attend the sessions of the Sectional Meeting, and the Hospital Conference. A varied program has been arranged to interest members of the several professions which are concerned with service to the sick and injured.

Of special interest will be the cancer clinic at the Western Pennsylvania Hospital, and the fracture clinic at St. Francis Hospital.

ACTIVITIES OF THE ILLEGAL PRACTICE COMMITTEE

THE BOARD OF MEDICAL EXAMINERS, ARTICLE NUMBER TWO

By CHARLES A. FUREY, D.O., Chairman; JOHN H. ROWLAND, M.D.;
GEORGE W. WILLIAMS, M.D., and ROYAL A. SCHAAF, M.D.,
Committee on Prosecutions

This is the second article in a series presented by the State Board of Medical Examiners of New Jersey. The first article was presented by Dr. A. Anderson, Lawton, President, and Dr. E. S. Hallinger, Secretary, on the "Activities of the State Board of Medical Examiners", in the Journal, January, 1941, page 42.

The Illegal Practice Committee was established under the Board of Medical Examiners for the purpose of investigating all complaints and violations of the Medical Practice Act. It is the duty of the committee to sift all evidence in each case, and to decide whether or not a misdemeanor was committed.

We do not want to give the impression that this committee has been set up to intimidate or threaten any person who is licensed to practice his profession in our State; but on the contrary, the Board desires to safeguard the health and lives of the public from charlatans and all other incompetent healers, and to protect the legally practicing physicians who have met all the requirements of the Medical Practice Act. Let us review some of the history of the progress made in this respect since the enactment of the Medical Practice Act.

HISTORY OF THE COMMITTEE

From 1890 until 1915, a violation of the Medical Practice Act was a misdemeanor which came under the Crimes Act. Enforcement was in the hands of the twenty-one county prosecutors. We have been unable to find a record of any cases having been prosecuted; but we have found many letters written by Dr. Norton, former Secretary of the Board, to persons who were violating the law. This seems to have been the only means of enforcement until 1915. At that time the law was amended through the efforts of The Medical Society of New Jersey, because of the fact that it was not being enforced by the prosecutors. A violation of the amended law was made a *penal offense*, thereby putting prosecutions in the hands of the Attorney General.

The Board found it difficult to enforce the law, since it provided for a jury trial; and it was not until 1921, when it was again amended to provide for trial without a jury, that the Board was able to secure convictions.

METHOD OF ACTION

When a complaint is received by the Board it is referred to the Illegal Practice Committee.

If the committee believes it warrants investigation, it is referred to the Inspector with instructions to investigate. If the law is being violated, the case is referred to the Attorney General for prosecution. The Board never discloses the name of the person making a complaint unless the person is willing to be known.

At least six investigators are employed by the Board. Some of them are sent to the alleged violator. They complain of any ailments they may have, just as they would to their own physicians. If they are treated, they continue until the Board has what they consider sufficient evidence on which to proceed. The reports which the investigators make immediately after each visit are referred to the Attorney General and if he considers the evidence sufficient, a complaint is prepared by him and signed by the Secretary of the Board. The violator is then arrested and tried without a jury.

In addition to the evidence of our investigators, we endeavor to secure some outside witnesses. Our inspector calls on the person who makes the complaint if it is signed. If it is a person who has been treated and is willing to testify, he or she is subpoenaed when the case comes to trial. If it is a physician and he is willing to give the name of the person he knows who has been treated, the person is subpoenaed; but if the physician does not wish to involve the patient, it does not interfere with the case since the Board proceeds on the evidence already obtained by the investigators.

We have been accused of prosecuting cases without cause; but this is not so. Nearly half of the complaints received are not signed; however, the information given is usually correct as proven by subsequent investigation. The only way which the violators are brought to the attention of the Board is through these complaints. The Board does not investigate except upon complaint.

Most of the violations coming to the attention of our committee involve druggists prescribing over the counter, and the limited-license practitioners. A very large number of

persons are prosecuted each year for violations of the Medical Practice Act. Many cases are investigated, but occasionally evidence is insufficient upon which to proceed.

So much for the scope and work of this committee. What can be done to extend the scope of its operation for the best interests of both the physicians, and the public?

ANNUAL REGISTRATION

There are several things that can be done. One is the *annual registration* of all licensed practitioners in our State; and another is the setting up of *County Society Illegal Practice Committees* to cooperate with this Board. There are some who oppose the idea of annual registration on the grounds that it would set the Medical Board up as a Bureaucracy. But that is not so, as shown by the Boards in other States where it has been in practice for many years.

Annual registration would give each member of these professions a complete list of licensed Medical Doctors, Osteopaths, and Chiropractors. Any man whose name did not appear on the list would undoubtedly be reported to the Board by some member of the profession in his community.

Every midwife and chiropodist in the State is required to register annually on or before the first of November. There is a penalty for failing to do this. A list of all midwives delivering patients is furnished to the Board, monthly, by the Bureau of Vital Statistics; and we can be sure that no unlicensed midwife practices in the State.

If the Board had an additional source of income, more investigators could be employed to cooperate with the various agencies throughout the State in order to discover many of the violations that are being made in every community in the State, such as medical doctors who have not the privilege of practicing in this State for one reason or other, or who may come across the border from another State where they have a license to practice, and physicians who come to Summer resorts during the Summer months and are licensed to practice in their own State but not in ours; osteopaths who are not licensed in our State, or who may be extending their limited privileges; and all other unlicensed practitioners, charlatans, religious cults, and healers of various kinds. Annual registration would provide such funds.

COUNTY COMMITTEES

The advisability of County and State Illegal Practice Committees to work as sub-committees to our committee is obvious. It would greatly facilitate our investigations and hasten considerably the time required for such work.

Both these projects, we feel, would be a great step forward in the prosecution of the work of this committee. But they cannot be accomplished without the cooperation of the County and State Medical, Homeopathic, and Osteopathic Societies, and all other organized groups of limited-license practitioners.

Our duties are not pleasant ones; but they must be performed efficiently in the best interests of all concerned.

THE STATE SOCIETY AWARD, 1941

The Medical Society of New Jersey has authorized an award of one hundred dollars for the best essay on an original medical subject, submitted according to the following rules:

1. Any medical or surgical subject may be selected.
2. The essay must be unpublished and of interest to the general practitioner.
3. Contributions must come from members of the Society who are in good standing.
4. The manuscript must not exceed 5000 words; and shall be typewritten in English, in manuscript form, with double spacing, wide margins and be

written on one side of the page, and five copies shall be submitted.

5. Manuscripts must be in the office of the Secretary of the State Society, Dr. Alfred Stahl, 55 Lincoln Park, Newark, N. J., not later than April 15, 1941.

6. The winner shall be determined by a secret Awards Committee composed of five members of The Medical Society of New Jersey. The officers of the State Society are not eligible for the award.

7. The winner shall be awarded a cash prize of \$100; and an invitation to present the contribution before the 1941 Annual Meeting of the State Society.

8. The Society reserves the right to make *no award*, if in the judgment of the committee no contribution is desirable.

TOWN HALL: REDUCED RATES FOR PHYSICIANS

The Griffith Foundation announces that physicians attending the Town Hall in Newark, March 24, to hear Dr. Frank Lahey take part in the celebration of the 175th Anniversary of The Medical Society of New Jersey, may secure tickets at reduced rates. The regular \$1.50 seats will be available to physicians at one

dollar each. To take advantage of this reduction, the doctor should send a request, written on his professional letterhead, to Griffith Foundation, 605 Broad Street, Newark. Check should accompany application, and the enclosing note should indicate that the ticket is to be credited to The Medical Society of New Jersey.

MATERNAL WELFARE CONFERENCE

The Annual Conference of the State Committee on Maternal Welfare with the County Committees, Field Physicians, and all interested physicians will be held at the Academy of Medicine, 91 Lincoln Park, Newark, on Thursday, April 17th, 1941.

Field Physicians' special meeting at 3 p. m.
Maternal Welfare Conference at 4 p. m.
Dinner at Essex House at 7 p. m.
Academy meeting at 9 p. m.
Dr. Frederick C. Irving, of Boston, speaker.
Please reserve this date.

LECTURES AT THE AURORA INSTITUTE

Each year the Aurora Institute, Morristown, N. J., conducts a series of lectures on endocrinological, neurological and metabolic subjects, to which the medical profession is invited.

The first lecture this year will be delivered on Sunday, March 30, at 5 p. m. in the Institute by Dr. H. O. Mosenthal, Clinical Professor of Medicine, Post-Graduate Hospital, New

York, on the subject "The Management of Diabetes".

The next lecture will be on Sunday, May 18, by Dr. Foster Kennedy, Professor of Neurology, Cornell University Medical College, on the subject "The Inter-relationship of Mind and Body".

After the lectures dinner will be served in the main dining room of the Institute to the physicians and their wives.

THE TRIAL OF THE AMERICAN MEDICAL ASSOCIATION

The trial of the criminal charges of the Federal Government against individual leaders of the American Medical Association and two of the component societies, began at 10 a. m., on Wednesday, February 5, 1941, in the District Court in Washington. A transcript of the stenographic report of the proceedings is published from week to week in the current issues of the A. M. A. Journal, the first installment being in the issue of February 15, pages 602-630.

After a jury of twelve persons and two alternates had been chosen, Mr. John H. Lewin, special prosecuting attorney, presented the indictment which consists of thirty printed pages, which charges violation of Section 3 of the Sherman Antitrust Act, in that the defendants boycotted and restrained the business operations of:

- A. The Group Health Association, Inc. (a medical coöperative organization of the District of Columbia).
- B. Twelve private Washington hospitals.

C. A number of doctors in private practice.

The principal charge was that the A. M. A. maintains bureaus, councils, and committees "Which concern themselves with medical economics or the business side of the rendition of medical care. The issue also promulgates a set of rules which makes it binding on all of its members, including the members here in the District of Columbia, who are members of the District Medical Society, and which rules embody some purely economic restraints upon the practice of medicine.

"Observance of these rules is enforced upon all the members in the first instance, by the various local medical societies. The observances of these rules is largely achieved because members are unwilling to suffer loss of prestige and professional ostracism which would result if they should be expelled from these societies or otherwise disciplined."

The prosecutor then described the Group Health Association which was incorporated on February 24, 1937, for the purpose of supply-

ing medical service to persons of low incomes in government employ. The Association obtained loans from the Federal Home Owners' Loan Corporation. The prosecuting attorney further said that he would show that the defendants proposed to suppress the Group Health Association by:

- A. Boycotting the Group Health Association.
- B. Keeping its members from serving on the medical staffs of institutions accepting Group Health Association patients.
- C. Preventing black-listed members from securing positions on any hospital staff.

The prosecutor stated that two of his principal witnesses were Dr. Hugh Cabot, and Michael Davis, Ph. D., and that these witnesses would "Give you the background of the conspiracy" (A. M. A. Journal of February 15, page 616, bottom of column two).

The prosecutor also stated that he would prove that the A. M. A. had exercised unlawful influence over physicians in California, Wisconsin, and Arkansas, and included the whole nation in the scope of its boycott.

The prosecutor also stated that he would prove that the real reason for the opposition of the A. M. A. was business and economic, and not the elevation of the standards of the practice of medicine.

In closing his introductory address to the court the prosecutor said: "The keystone of the conspiracy is the economic purpose of the defendants to destroy legitimate competition in the practice of medicine in the District of Columbia."

DEFENDANT'S OPENING STATEMENT

William E. Leahy, attorney for the defendant (the A. M. A.), outlined the evidence that would be presented by the defense. He described the action of the Federal Congress on February 16, 1819, granting a charter to the District Medical Society,—the first scientific society to be chartered by Congress.

He also described the formation of the A. M. A. in 1847; and denied that either Society is "In business".

He also outlined the inter-relations of the medical societies of the counties and States to the A. M. A.; and also the scope of the "Principles of the American Medical Association".

He referred to the opposition of the A. M. A. to unethical statements of those who advertise, as did the Group Health Association—"You can budget your sickness expenses. You can pay so much a month and get adequate medical care."

Mr. Leahy then described the "Coöperative League" established in Boston in 1910, by E. A. Filene, which became the "Twentieth Century Fund", and still later "The Health Economics Association, Inc." These organizations became affiliated with the Home Owners' Loan Association, and from them there developed the "Group Health Association".

The promoters of the Group Health Association ignored the Medical Society of the District of Columbia, and consulted a physician who engaged in unethical medical advertising. During its development the promoters refused to consult the District Medical Society, but issued the statement: "After the plan is ready to launch, then let us try to get the coöperation of the District Medical Society."

Mr. Leahy referred to a resolution adopted by the Medical Society before the G. H. A. was formed, that its members should not have professional relations with those who are engaged in the practice of medicine under contracts which had not yet been approved by the District Medical Society. This resolution had been adopted on the advice of a prominent attorney whom the Society will place upon the witness stand.

Mr. Leahy also described a conference at which the representatives of the Group Health Association refused to inform the committee of the Medical Society regarding the source of the Group Health Association's funds. The physicians said that they would coöperate with the Group Health Association if they knew where its money is coming from; and if the plan is economically sound, is ethically conducted and is in accord with public interest. The reply of the G. H. A. group was: "It is none of your business where our money is coming from."

Mr. Leahy also described several occasions in which the Medical Society sought information from the G. H. A. in sincere efforts to reach an ethical agreement regarding its distribution of medical services; but the requests of these physicians were always denied.

Mr. Leahy also outlined the essential changes made by the G. H. A. in its rules and regulations in order that they conform to legal standards of the courts.

A major point of the Counsel for the Defense was that the representatives of the A. M. A. had made sincere efforts to consult with those of the Group Health Association, and that they had found the G. H. A. group extremely uncoöperative.

The record of the trial will be continued in the April Journal.

OBITUARIES

DR. EDWARD F. LEONARD

Dr. Edward F. Leonard, aged 42 years, of Paterson, N. J., died on January 27, 1941, following an operation for intestinal obstruction, which began four days previously. He was born in Paterson on January 7, 1899. He graduated from Georgetown Medical College in 1924, and interned in Providence Hospital, Washington, D. C., and then remained as resident physician for two years. He began to practice in Paterson in 1928, as resident physician at St. Joseph's Hospital.

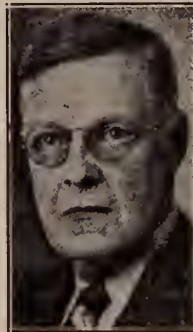


Dr. Leonard was active in the Passaic County Medical Society, and was highly respected by his colleagues for his professional ability, his fine personal qualities, and his kindly humor.

The Passaic County Medical Society passed resolutions of appreciation of Dr. Leonard's life and services.

DR. OSCAR A. MOCKRIDGE

Dr. Oscar A. Mockridge, of Montclair, N. J., aged 57 years, died in the Neurological Institute, New York, on January 25, 1941, following an operation. He was born in Newark on March 29, 1883, and attended the Newark Academy and the Penn Military College; and graduated from the College of Physicians and Surgeons in 1906. He interned in the City Hospital, Newark, and has practiced in Newark and Montclair. He specialized in pediatrics and was on the staffs of the Babies' Hospital and the Presbyterian Hospital, Newark, and the Community Hospital, Montclair.



During the World War he served in Base Hospitals in the South.

DECEASED PHYSICIANS OF NEW JERSEY — JANUARY, 1941

Name	Age	Date of Death	Place of Death	Residence	Cause of Death
F. Halstead Brown	60	Jan. 18, 1941	Roselle Park	Same	Broncho pneumonia.
Samuel H. Iams	61	Jan. 18, 1941	Princeton	Same	Cerebral thrombosis.
George G. Jackson	63	Jan. 8, 1941	Newark	Same	Uremia
Matilda A. Jardine	92	Jan. 22, 1941	East Orange	Newark	Pneumonia.
William J. Lein	68	Jan. 30, 1941	Greystone Park	Same	Carcinomatosis.
Edward F. Leonard	42	Jan. 27, 1941	Paterson	Same	Intestinal obstruction.
Joseph McDede	67	Jan. 28, 1941	Jersey City	Same	Uremia.
Frank H. Warncke	58	Dec. 26, 1940	Elizabeth	Same	Broncho pneumonia.
James W. Wilson	72	Jan. 22, 1941	Madison	Same	Cerebral hemorrhage.

The ages at death varied from 42 to 92 years with an average of 62 years. Three of those dying were members of their County Societies.

NUMBER OF CHILDREN REPORTED RECEIVING FREE STATE BIOLOGICALS
SINCE JULY 1, 1940

DIPHTHERIA TOXOID

County	Total to Dec. 31	Month of Jan.	Total to Jan. 31	Average per Month
Atlantic	6945	68	7013	1001.8
Bergen	1393	293	1686	240.8
Burlington	107	198	305	43.5
Camden	1036	7	1043	149.
Cape May	20	1	21	3.
Cumberland	69	2	71	10.1
Essex	4653	783	5436	776.5
Gloucester	66	5	71	10.1
Hudson	1565	294	1859	265.5
Hunterdon	25	81	106	16.5
Mercer	1248	124	1372	196.
Middlesex	367	4	371	53.
Monmouth	934	26	960	137.1
Morris	378	22	400	57.1
Ocean	35	115	150	21.4
Passaic	2818	141	2959	422.7
Salem	201	1	202	57.8
Somerset	205	33	238	34.
Sussex	3	0	3	.4
Union	1172	72	1244	177.7
Warren	50	4	54	7.7
Totals	23290	2274	25564	3652.

SMALLPOX VACCINE

County	Total to Dec. 31	Month of Jan.	Total to Jan. 31	Average per Month
Atlantic	630	18	648	92.5
Bergen	972	113	1085	155.
Burlington	217	28	245	35.
Camden	1259	12	1271	181.5
Cape May	53	1	54	7.7
Cumberland	124	0	124	17.7
Essex	4622	374	4996	713.5
Gloucester	198	4	202	57.8
Hudson	2200	9	2209	315.5
Hunterdon	21	0	21	3.
Mercer	836	16	852	121.7
Middlesex	606	6	612	87.4
Monmouth	347	2	349	49.8
Morris	481	13	494	70.5
Ocean	21	0	21	3.
Passaic	1823	79	1902	271.7
Salem	233	0	233	33.2
Somerset	126	13	139	19.8
Sussex	21	0	21	3.
Union	1031	62	1093	156.1
Warren	188	2	190	27.1
Totals	16009	752	16761	2394.4

COUNTY SOCIETY REPORTS

COUNTY SOCIETY COMING MEETINGS

MARCH, 1941

4 Camden	13 Passaic
4 Hudson	13 Somerset
11 Bergen	14 Atlantic
11 Cape May	19 Middlesex
12 Mercer	20 Gloucester
12 Ocean	20 Morris
12 Union	21 Salem
13 Burlington	26 Monmouth
13 Essex	

APRIL, 1941

1 Camden	10 Passaic
1 Hudson	10 Somerset
8 Bergen	11 Atlantic
8 Cape May	15 Warren
8 Cumberland	16 Middlesex
9 Mercer	17 Gloucester
9 Ocean	18 Salem
9 Union	22 Hunterdon
10 Burlington	23 Monmouth
10 Essex	

ATLANTIC COUNTY

Charles Hyman, M.D., Reporter

The regular monthly meeting of the *Atlantic County Medical Society* was held as a combined meeting with the Cape May County Medical Society, at the Hotel Ambassador, Atlantic City, February 14, 1941. Dr. V. Earl Johnson, President of the Atlantic County Society, presided.

GUEST SPEAKER

The guest speaker was Lt. Col. Arthur P. Hitchens, Medical Corps, Professor of Preventive Medicine at the University of Pennsylvania Medical School. His topic was "The Medical Profession and the Present Mobilization". He emphasized the importance of home security as to health and disaster as it affects civilian population in the new type of warfare. Not enough attention has been paid to the opportunities in preventive medicine in peacetime. It is hoped that, with the awakening of the country to the need for total defense, some effort will materialize to prevent the entirely preventable diseases, such as diphtheria, scarlet fever, syphilis and tuberculosis. Although the armed forces of the nation will be under strict and efficient health supervision, this program can break down unless the home front is adequately protected from the same dangers.

The paper was discussed by Drs. Kilduffe, Salasin, and Scott.

COÖPERATION IN NATIONAL DEFENSE

Dr. Thomas K. Lewis, President-Elect of the State Society, paid an official visit, and commented on the medical aspects of the present emergency. He emphasized the importance of sending in the questionnaires.

The State Society has been assured by the War Department that no doctor will be called for service unless the right place in the service is available. Commissions will be awarded commensurate with the work done and the training of the doctor before entering the service. He urged that an effort be made to coördinate all the preparedness activities in the community under one leadership.

The Medical Service Administration was further discussed by Dr. Scanlon of the Insurance Committee; Dr. Carrington, member of the Board of Governors; and Mr. Harty, Executive Secretary of the Plan.

MEMBERSHIP

Dr. Morris Gottlieb was unanimously elected to membership.

BURLINGTON COUNTY

T. Bruce Dickson, M.D., Reporter

The regular monthly meeting of the *Burlington County Medical Society* was held on February 13, 1941, at the Moorestown Field Club with thirty members present.

SCIENTIFIC

The guest speaker was William H. Schmidt, M.D., who spoke on "The Value of the Surgical High Frequency Current to the General Practitioner". Dr. Schmidt is Professor of Physiotherapy at Jefferson Medical College. His talk was illustrated with lantern slides which demonstrated the fine work being accomplished in this branch of medicine.

ESSEX COUNTY

Paul H. Hosp., M.D., Reporter

The regular monthly meeting of the *Essex County Medical Society* was held in the Academy of Medicine, Thursday, February 13, 1941, at 9 p. m., with President Harry N. Comando presiding, and every seat in the auditorium filled.

SCIENTIFIC

Dr. Harrison S. Martland, Chief Medical Examiner of Essex County, introduced the speaker of the evening, George R. Minot, M.D., Professor of Medicine, Harvard University, who spoke on the subject "Etiology, Diagnosis, and Treatment of the Anemias". The topic was so interestingly and clearly given that the time allotted seemed all too short. Everyone present went home feeling that the evening had been well spent.

MEMBERSHIP

The following physicians were admitted to membership:

Active:

J. R. Gilmour, East Orange
C. A. Wallenstein, Newark

Associate:

John J. Balsamo, Newark
Louis L. Covino, Newark
J. L. Greenberg, Newark
Mortimer Greenberg, Hillside
Frank J. Saracino, Arlington

MEDICAL FORUMS

The Public Relations Committee's program of Public Medical Forums,—which are held in the auditorium of the Mutual Benefit Life Insurance Company in Newark,—had for its speaker at the opening meeting on January 21 Dr. Robert S. Goodheart, of New York University College of Medicine, whose subject was "Vitamins".

A motion picture with the title—"That You May Live"—was shown, in order to illustrate the modern treatment of pneumonia.

On February 25, Dr. Joseph Runion of the New York University College of Medicine talked on "Miracle Drugs"—the sulfanilamide group. A motion picture, "Jenner and Smallpox", was also given.

These forums are for lay people, but it is hoped many doctors will attend.

ANNIVERSARIES

During the present year Essex County will take part in celebrating two anniversaries:

1. That of The Medical Society of New Jersey,—the 175th—which was founded on June 23, 1766.
2. That of the Essex County Medical Society—the 125th—which was founded on June 4, 1816, in accordance with a law of February 16, 1816, which authorized the State Society to grant charters to component county medical societies.

FIFTY YEARS OF PRACTICE

At the March meeting certificates of appreciation will be given to about twenty men of the Essex County Medical Society who have been practicing physicians for fifty years or more.

ACADEMY OF MEDICINE OF NORTHERN
NEW JERSEY

Franklin J. Tobey, M.D., Secretary

The stated meeting of the Academy of Medicine of Northern New Jersey was held on Thursday, February 20, 1941, at 9 p. m., under the auspices of the Eye, Ear, Nose and Throat Section, with the President, Dr. Charles M. Robbins, presiding.

William O. Wuester, M.D., Hillside, was elected to Fellowship.

Dr. Elias J. Marsh, First Vice-President of The Medical Society of New Jersey, addressed the Section about the Charles J. Kipp Memorial Fund, of which he is Treasurer. The fund was established several years ago to promote research in eye, ear, nose, and throat, but has never been increased or used. Dr. Marsh said that the disposal of the fund will be decided at the State Society meeting in May.

Dr. Robbins turned the meeting over to Dr. Charles W. Barkhorn, Chairman of the Eye, Ear, Nose, and Throat Section.

Dr. Barkhorn introduced the guest speaker, Dr. Walter I. Lillie, Professor and Head of the Department of Ophthalmology, Temple University School of Medicine, Philadelphia. His paper on "Fundal Changes Associated with Arterial Hypertension" was of great practical interest to the audience. The subject was illustrated by lantern slides.

Drs. Francis Weber, Rados, Hahn, Hughes and A. Russell Sherman discussed the paper.

PROGRAM FOR MARCH, 1941

Council	Thurs., March 6
Eye, Ear, Nose and Throat	Mon., March 10
Medicine and Pediatrics	Tues., March 11
Stated Meeting, 30th Anniversary ..	Thurs., March 20
Surgery	Tues., March 25

Eye, Ear, Nose and Throat Section, Monday, March 10th, 8:45 p. m.

Paper: "Head Pain." S. Bernard Wortis, M.D., Associate Professor of Neurology, New York University College of Medicine, New York.

Medicine and Pediatrics Section, Tuesday, March 11th, 8:45 p. m.

Paper: "Recent Studies on Food Allergy" (illustrated). Arthur F. Coca, M.D., Pearl River, New York.

Discussion opened by A. Sumner Price, M.D., Pathologist, New York Polyclinic Hospital, New York.

Stated Meeting, Thirtieth Anniversary, Thursday, March 20th, 9 p. m.

"A History of the Academy of Medicine, 1911-1941", by the President, Charles M. Robbins, M.D.

"Anniversary Address." Hugh H. Young, M.D., Professor of Urology, Johns Hopkins University, Baltimore, Md.

Surgery, Tuesday, March 25, 1941, 8:45 p. m.

Paper: "The Early Diagnosis and Management of Appendicitis in Childhood" (illustrated). R. Franklin Carter, M.D., Associate Professor of Surgery, New York Post-Graduate Medical School, Columbia University, New York.

All physicians and medical students are invited to the scientific meetings.

Physicians, their friends and the laity are invited to the Thirtieth Anniversary Meeting.

GLOUCESTER COUNTY

C. A. Bowersox, M.D., Reporter

The monthly meeting of the *Gloucester County Medical Society* was held at the Woodbury Country Club, February 20, 1941, President Henry B. Diverly presiding.

MEDICAL PREPAREDNESS

Dr. William Pedrick reported on the suggestion that all of the three examining boards in the county be grouped into one and hold examinations in the Woodbury Armory. There is urgent need for more men on these boards; and he suggested at least five additional in each of the three districts. Dr. Norman M. Scott, of Trenton, then made a few suggestions on the same topic, concerning the advisability of grouping all the boards, and as a result, meeting less frequently.

SCIENTIFIC

Dr. J. Alexander Clark, Jr., of Philadelphia, gave an address on "Respiratory Allergy,—Practical Points in Diagnosis and Treatment". The address was intensely practical and interesting.

MEDICAL SERVICE ADMINISTRATION

Dr. Norman M. Scott then presented "Medical Service Administration in New Jersey" to the Society. He stated it would be necessary that 51 per cent of the practitioners of medicine in Gloucester County sign the agreement that was enclosed in the February Journal, in order that the project may be put in operation in the county.

Editor's Note—Since the date of the meeting, more than 60 per cent of the physicians of Gloucester County have signed the agreement.

HUDSON COUNTY

John N. Connell, M.D., Reporter

A regular meeting of the *Hudson County Medical Society* was held on Tuesday, February 4, 1941, at the Masonic Club, at 9:30 p. m., with the President, Dr. George Ginsberg, presiding.

The President announced that Dr. Henry Spence is undergoing an operation in a hospital. It was voted that the Secretary send him the best wishes of the society.

DINNER

Dr. Conty, Chairman of the Dinner Committee, announced that the Annual Dinner of the Hudson County Medical Society would be held on Saturday, February 15th, at the Masonic Club. The Toastmaster will be Dr. James F. Norton, and the speakers will be Dr. Harrison Martland and Senator Lou Mines. Tickets may be purchased from Dr. W. J. Snyder.

STATE SOCIETY REPRESENTATIVES

Dr. Thomas K. Lewis, President-Elect of The Medical Society of New Jersey, gave a brief resume of work of the Society.

Dr. Watson B. Morris, President of The Medical Society of New Jersey, gave a detailed report of the McClave Act. The Act was also discussed by Drs. A. E. Jaffin, and P. E. Maras.

Dr. Elton W. Lance spoke on the Medical Service Administration, and urged the doctors to sign the forms which were distributed in order that this plan may be operated on a State-wide basis in the near future.

MEMBERSHIP

Four physicians were elected to membership:

Carmine J. Cufari, Union City
Henry Clay Irving, Jersey City
Armand M. Milanese, Union City
Louis F. Sciarrillo, Hoboken

Two proposals for membership were received.

SCIENTIFIC

Dr. Ginsberg introduced Dr. Thomas Cherry, Professor of Gynecology, New York Post-Graduate Medical School and Hospital, who spoke on "Office Gynecology".

MIDDLESEX COUNTY

Cyril I. Hutner, M.D., Reporter

The monthly meeting of the *Middlesex County Medical Society* was held on February 19, 1941, with the President, Dr. R. J. Faulkingham, presiding.

The Secretary announced that the dues of members in the Army would be paid by the Society.

SCIENTIFIC

Dr. William G. Leaman, Jr., Professor of Cardiology of the Woman's Medical College, Philadelphia, gave a paper on "Curable Types of Heart Disease". This was discussed by Drs. Estelle Kleiber and J. H. Rowland.

OFFICE DIRECTORY

It was voted that a Medical Directory be purchased for the use of the office of the society.

OUTING

An invitation was accepted from the County Dental Society to join it in an annual outing in May.

MEDICAL SERVICE ADMINISTRATION

Dr. N. M. Scott, Medical Director, Medical Service Administration, presented its three plans. The society approved the Farm Security Plan.

POST-GRADUATE

Dr. I. J. Fine, Chairman of the Post-Graduate Committee, reported that six lectures are planned, three in New Brunswick and three in Perth Amboy.

Refreshments were served after the session.

MONMOUTH COUNTY

Murray Woronoff, M.D., Reporter

The regular meeting of the *Monmouth County Medical Society* was held on January 22, 1941, in the Garfield-Grant Hotel, Long Branch, N. J., at 9 p. m.

MEMBERSHIP

Dr. Stephen Casagrande, Belmar, was elected to membership; and one application for membership was received.

SCIENTIFIC

Dr. Frank L. Mulleney, Associate Professor of Clinical Surgery at Columbia University, spoke on "The Treatment of Surgical Infections".

Dr. Norman M. Scott, Executive Assistant, The Medical Society of New Jersey, described the Medical Service Administration.

OCEAN COUNTY

Raymond A. Taylor, M.D., Reporter

A regular meeting of the *Ocean County Medical Society* was held at the Paul Kimball Hospital, Lakewood, N. J., at 8:30 p. m. on Wednesday, February 12th, 1941, with President William E. Dodd presiding.

SCIENTIFIC

An excellent scientific program was carried out as follows:

1. "Secondary Breast Tumors", Dr. Stanley P. Reimann, Director of the John Wanner Foundation for Cancer Research, Philadelphia.
2. "The Woman with a Lump in Her Breast", Dr. J. Stewart Rodman, Professor of Surgery, Woman's Medical College, Philadelphia.

THE MEDICAL SERVICE PLAN

Dr. Norman M. Scott, of Trenton, discussed the Medical Service Plan of New Jersey and its workings. The project was unanimously endorsed by the society.

It was decided to hold Ladies' Night on the 22nd of March, 1941.

PASSAIC COUNTY

Irving Okin, M.D., Reporter

The regular monthly meeting of the *Passaic County Medical Society* was held at School No. 13, February 13, 1941, with Vice-President, Dr. Sigurd W. Johnsen, presiding.

MEMBERSHIP

The following physicians were elected to membership:

Active membership:

Martin Jay Ackerhalt, Clifton

Gustav Farkas, Passaic

Associate membership:

Michael Alexander Ogden, Passaic

Edward C. Thompson, Paterson

Frank R. Visceglia, Passaic

Erich Wolf, Passaic

One application for active, and one application for associate membership were read.

DINNER DANCE

Announcement was made of the dinner dance to be held by the Woman's Auxiliary at the North Jersey Country Club on March 29. Further announcements will be made in the Bulletin.

LABELLING DRUGS

Dr. Yager, the Secretary, reported on further correspondence with regard to the Food and Drug Act. According to an opinion received from the Attorney General of the State of New Jersey, no labelling of drugs dispensed by the physician is necessary. However, an amendment is being prepared by the New Jersey Pharmaceutical Association, which, if passed, may require labelling in the future.

Dr. Harold E. B. Pardee, Assistant Professor of Clinical Medicine, Cornell University Medical School, spoke on "Management of Patients with Rheumatic Fever, Particularly in Regard to Cardiac Complications". Dr. Pardee gave a very concise and interesting summary of the modern treatment of rheumatic conditions, and stressed the important points in the care of the patient following his recovery from the acute infection. There was discussion and questions by many of the members.

Dr. Norman M. Scott, Director of the Medical Service Administration, outlined the history of the Plan, and the details of how it would work. He asked all physicians to sign the agreement to participate which accompanied the February issue of the Journal.

WARREN COUNTY

H. B. Bossard, M.D., Reporter

The Winter meeting of the *Warren County Medical Society* was held in the Elks' Club, Phillipsburg, January 18, 1941, at eleven o'clock, with the President, Dr. Ralph Buchanan, of Phillipsburg, presiding.

Dr. Clyde Smith's private hospital at Washington was approved.

MEDICAL SERVICE ADMINISTRATION

Mr. Harty, of the Medical Service Administration, explained the medical service, and urged the members to sign the participating agreement.

Dr. LeRoy Wilkes, Executive Secretary of the State Society, was present and spoke on the Medical Service Administration and other subjects pertaining to the welfare of the Society.

The meeting adjourned to the dining room where the members of the society were joined by the ladies of the Auxiliary at luncheon.

SUMMIT MEDICAL SOCIETY

Elwood H. Macpherson, M.D., Secretary

The *Summit Medical Society* held its January meeting on Tuesday evening, January 28th, at the Nurses' Home at Overlook Hospital, with Dr. F. R. Stuart, the Vice-President, presiding. There were nineteen members and three guests present.

Dr. John W. Gray, of St. Barnabas Hospital in Newark, gave an illustrated talk on "Gold Therapy in Arthritis". This was followed by colored motion pictures.

After the meeting a collation was served.

NORTHERN NEW JERSEY DERMATOLOGICAL SOCIETY

Cedric C. Carpenter, M.D., Secretary

The *Northern New Jersey Dermatological Society* met on January 22, 1941, at the Academy of Medicine in Newark. Due to the illness of Dr. Heller, Dr. Francis J. McCauley presided.

SPOROTRICHOSIS

A case of sporotrichosis was demonstrated by Dr. Nathan Scheffer, of East Orange, by invitation. It is quite unusual to see this deep type of fungus infection in the East. This man's condition had begun as a result of being scratched by a straw on his forehead. He had two secondarily transplanted lesions on his left arm and forearm, due to scratching. The only difficulty in such a type of case is to recognize its true nature, and these patients are often treated for boils before the culture is made. However, in this condition, syphilis, tuberculosis, tularemia, and blastomycosis must be excluded. Occasionally there is also chest involvement, and x-rays should be taken in all cases.

This condition may be treated by the use of iodides internally in large doses, and if they are intolerant to these, thymol should be used.

TREATMENT OF EARLY SYPHILIS

A case of five-day treatment for syphilis was presented by Dr. John Kiley and Dr. H. L. Sutton. This patient still has remnants of his primary lesion, while all secondary lesions have faded. It has been Dr. Kiley's experience that this type of treatment is useful in the sero-negative, primary type of syphilis. He has also found that the drug,

mapharsen, produces less reactions than neoarsphenamine in this form of treatment. He was also of the opinion that further treatment be given if the serology is not negative at the end of a course of therapy.

This particular patient was a man, 27 years of age, and during the five days that he remained in the isolation hospital, he received 0.24 grams of mapharsen daily. His only complaint was a pain in the vein due to the needle, and some nausea. There was no change in his serology during the course of treatment.

STATE MEETING

It was requested by the Board of Trustees that we do not form a State Section of Dermatology this coming year. The 175th meeting this year at Atlantic City will be devoted mostly to the welfare of the general practitioner and his problems, and it is considered better for the men who wish to present papers to do so at either the General Medical or the Surgical Section.

Dr. McCauley presented the possibility of the dermatologists in the State organizing some sort of a clinical day of their own to be held at some suitable place, and at some time other than that of the State Society meeting.

Dr. H. L. Sutton, of Newark; Dr. J. Bleiberg, of Newark; and Dr. O. Sokoloff, of New Brunswick, were elected to membership.

PHYSICAL THERAPY PHYSICIANS

Robert F. Dow, M.D., Secretary, Paterson, N. J.

The monthly meeting of the *New Jersey Society of Physical Therapy Physicians* was held in the Academy of Medicine in Newark, on January 30, 1941.

Preceding a short business meeting there was a scientific session devoted to two papers. The first paper,—"Electricity in Medicine, Part One,"—was offered by Eugene Charbonneau, M.D., of East Orange, who is a pioneer in physiotherapy. The second paper,—"The Combined Physiotherapeutic and Medical Management of the Allergic Syndrome,"—was presented by Robert F. Dow, M.D., of Paterson. It emphasized the physical findings in allergy, and the ameliorating influence of ultra-violet and short-wave diathermy on the allergic episodes.

BOOK REVIEW

PHYSICAL DIAGNOSIS. By Ralph H. Major, M.D. 2d ed. Pp. 464. Philadelphia, W. B. Saunders Co. 1940. \$5.00.

This volume on diagnosis should grace every practitioner's library. It will be found to be a handy reference at all times, especially to the gen-

eral practitioner. Many changes have been made in this new edition and numerous illustrations added. Its logical and accurate presentation, together with its details, make it a valuable book, which ranks high as an outstanding volume in the field of diagnosis.

FERDINAND C. DINGE, M.D.

WOMAN'S AUXILIARY

COMING EVENTS

ATLANTIC COUNTY

March 14, 1941, 9:00 p. m.

Discussion subject: Legislation

BURLINGTON COUNTY

April 7, 1941, 7:00 p. m.

Soroptimist Club, Garden Street, Mt.

Holly, N. J.

Election of officers

Dinner

ESSEX COUNTY

March 24, 1941, 2:00 p. m.

Academy of Medicine, Newark, N. J.

Activity relative to the commemoration of the 175th anniversary of the founding of The Medical Society of New Jersey

GLOUCESTER COUNTY

March 20, 1941, 9:00 p. m.

Business and social meeting

HUDSON COUNTY

April 6, 1941, 2:00 p. m.

Theatre party

PASSAIC COUNTY

March 17, 1941, 3:00 p. m.

Woman's Club, Paterson, N. J.

Business and social meeting

WARREN COUNTY

March 18, 1941, 1:00 p. m.

New Palm Garden, Route 24, New Philippsburg, N. J.

Luncheon bridge

ART, HOBBY, AND MEDICAL HISTORY EXHIBIT

By MRS. ILY R. BEIR, Atlantic City, N. J., Chairman

We are living in times that require pioneer effort. There is nothing sure any more. No longer may we order our lives by established routine. We must face untried conditions for whatever we desire. This is a time when we must determine what we have, our needs, the obstacles, choice of methods, and where and to what all may lead. We must solve new, untried, and even unknown conditions, and internal and external problems that involve the existence and security of our nation, and our very lives as well as the means of livelihood for us and our families. That we face danger and failure, all of us must realize; but we should know that our united efforts will attain a success that will be all the more precious because it will come through hardship and will unite us more closely.

"The American Way of Life" is a beautiful thing because it has always secured the things needed for self-preservation in just this way, and not through the totalitarian method. Though they are universal in any government or effort, selfishness and greed must be combatted by the remembrance that the lessons of the philosophy, the experience, and the aims of a God-loving people teach the brevity of the

triumph of such unworthy efforts, and the emptiness of the rewards of such attainment.

MEDICAL HISTORY

That we, who are here, may profit by the examples and lessons of the past, the Art, Hobby, and Medical History Committee initiated the methodical collecting and recording of the history of our county and State medical men and their organizations for the Archives of The Medical Society of New Jersey. As the past is now being recorded there, so will the present and future when they too are past, all to serve as guides for us and those yet to come. The State Medical Society and our Auxiliary have encouraged and helped us in every way. They and the chairman of this committee appreciate all the time and effort given by county committees.

EXHIBITS

Curiosity, desire for the unusual, and love of the beautiful, are common to all, as is our desire to share our pleasures with others. Our exhibition is the result of the creation of a community effort in the showing of such articles as we ourselves hold dear, for the education, entertainment and approval of our

friends, members of our societies and those with similar tastes. From small beginnings, this exhibition has grown greatly because it provided an outlet for a popular aspiration. In recent years, the results of our medical history work have also been shown so that our exhibition has become of much interest to doctors, as well as to their families, and a considerable attraction at the Annual Meeting. To secure this result, much planning, sacrifice, and co-operative effort have been required and secured from officers of our societies, from members of this committee, and from those who have generously entered their treasures for exhibition. To all I extend my grateful appreciation and congratulation, for my success is yours also.

To stand still is to go back for the world moves on. This year our State Medical Society

will celebrate its 175th anniversary at the Annual Meeting. Every officer and chairman in it and our Auxiliary will put forth every effort to make the occasion worthy of its traditions and future. Our exhibition must be outstanding. This means that county subcommittees must work diligently to prepare much medical history data; and to secure many art and hobby entries; that members or their families should be eager to enter for exhibition any article or collection that may be of interest because of its beauty, rarity, uniqueness or historical value, so that we may do our part. The coöperation and support of many is vital to our success. If any of us leaves it for the other fellow to do, we will fail. Soon letters and entry blanks will be sent to all county medical societies, the county auxiliaries, and to past and prospective exhibitors.

STATE AUXILIARY BOARD

The State Board of the Auxiliary will meet at the Essex House, Newark, N. J., on March 10, 1941, at 11:00 a. m. Mrs. R. J. McDonald, President, will preside. A luncheon will be served at 1:00 p. m.

PUBLIC RELATIONS MEETING

The annual Public Relations meeting of the New Jersey Auxiliary has been scheduled by Mrs. O. R. Carlander, Public Relations Chairman, for Tuesday, March 25, 1941, at 10:30 a. m., in the Camden Woman's Club, 424-26 Linden Street, Camden, N. J. An all-day meet-

ing is planned, with luncheon and a social hour at noon. The theme of the meeting will be "Health Inventory". Speakers will be announced later.

THE A. M. A. AUXILIARY

Hotel Carter will be the headquarters for the Annual Meeting of the Woman's Auxiliary to the American Medical Association, which will be held in Cleveland, June 2-6, 1941. Requests for reservations should be sent immediately to Dr. Edward F. Kieger, Chairman of the Committee on Hotels and Housing, 1604 Terminal Building, Cleveland, Ohio.

COUNTY AUXILIARIES

Atlantic County

Reported by Mrs. Matthew Molitch, Publicity Chairman

The regular meeting of the *Woman's Auxiliary to the Atlantic County Medical Society* was held on Friday, February 14, 1941, with Mrs. Anthony G. Merendino presiding. There were fourteen members present.

Reports were received from the Legislation Chairman, Mrs. G. Ruffin Stamps; the Press Chairman, Mrs. Matthew Molitch; and the Public Relations Chairman, Mrs. Rolfe Westney.

Several of the members gave a play dealing with a hospital, a nervous patient, and her nurses and visitor.

Camden County

Mrs. E. Reed Hirst, Publicity Chairman

The executive meeting of the *Woman's Auxiliary*

to the *Camden County Medical Society* was held Tuesday morning, February 4, at 10:00 o'clock at the home of the President, Mrs. L. L. Glover, with eighteen members present, and Mrs. Glover presiding.

Plans are well under way for a card party and fashion show which the Auxiliary will sponsor on Monday evening, March 3, at 8:00 o'clock, in the Walt Whitman Hotel, Camden, N. J. This party is given annually for the benefit of the various Camden County charities to whom the Auxiliary contributes.

The Legislative Chairman, Mrs. A. H. Lippincott, read the "Platform of the American Medical Association", and will distribute a copy to each Auxiliary member at the March meeting.

Mrs. Lippincott also presented a plea for assistance from the committee on "Greek War Relief". Several members of the Auxiliary offered to give

luncheons and card parties, if approved by the County Medical Society, to raise money for this needy cause.

Mrs. O. R. Carlander, Public Relations Chairman, reported that the annual *Public Relations Meeting* will be held on March 25, at the Woman's Club, 424-26 Linden Street, Camden, N. J. Representatives of all interested civic and social groups will be invited to attend. An all-day meeting is being planned with luncheons, in charge of Mrs. O. W. Saunders, Hospitality Chairman, followed by a social period, at noon.

Mrs. Carlander announced an invitation to the members of the Auxiliary to a banquet sponsored by the American Association of University Women, on March 4, at the Walt Whitman Hotel, 6:30 p.m. Drs. Mary E. Woolley and Kathryn MacHale will be the guest speakers.

Coffee was served at 9:40 by our hostess.

Essex County

Reported by Mrs. Frank S. Forte, Chairman of Publicity

The *Woman's Auxiliary to the Essex County Medical Society* held its regular monthly meeting on Monday, January 27, 2 p.m., at the Academy of Medicine, with Mrs. J. Irving Fort, President, presiding.

Mrs. Edward Flynn resigned as co-chairman of the Ways and Means Committee, and Mrs. Jesse T. Glazier, Newark, was appointed in her place.

Mrs. Charles Morrow resigned as Recording Secretary, and was succeeded by Mrs. Theodore Ford, Newark.

Mrs. R. Hunter Scott, Newark, was appointed Chairman of the Nominating Committee.

Mrs. Alan O. Godfrey and Mrs. Harold Hantman, both of Newark, were elected to membership.

The members voted to organize a group to take a course in "Home Hygiene and First Aid", offered by the Red Cross.

Mrs. Stuart Hawkes, Program Chairman, introduced the guest speaker, Mrs. Howard Hymer, of Red Bank, who gave a very interesting talk on "American Foreign Policy in a World of Conflict". Mrs. Hymer is a member of the International Relations Committee of the American Association of University Women.

Mrs. William Donahue, Public Relations Chairman, announced that *Health Institute Day* would be held on March 24, at 2 p.m., at the Academy of Medicine. Major Julia Stimson, who was Commandant of all the nurses during the World War, will be the guest speaker. This day will be part of the celebration in commemoration of the 175th anniversary of the founding of the New Jersey Medical Society, on July 23, 1766.

During the meeting members sewed for the Red Cross. Tea was served at the close of the meeting.

Hudson County

Reported by Mrs. Sydney Chayes, Chairman of Publicity

A regular meeting of the *Woman's Auxiliary to the Hudson County Medical Association* was held

Monday, February 3, at the Young Women's Christian Association, Jersey City, N. J. Mrs. Arthur Largay presided.

Mrs. Andrew Ruoff, Chairman of Public Health, reported that invitations have been issued for a Reciprocity and Public Health Meeting, March 3, 1941, at the Jersey City Y.W.C.A. Dr. George S. Kerdasha, of West New York, will speak on "Preventable Diseases", and Dr. Julius Heilbrunn, of Jersey City, will speak on "Child Psychology".

Mrs. William Friele, Co-chairman of Entertainment, announced that the sum of three hundred dollars was realized at the Fashion Show, Card Party and Tea held January 18, at the Hotel Pierre, New York City.

Mrs. R. F. McDonald, of Paterson, President of the State Woman's Auxiliary, was a guest at the meeting, and gave a short address. Mrs. Ruffin Stamp, of Pleasantville, N. J., reviewed "Shadow on the Land", by Dr. Thomas Parran.

The Auxiliary voted the sum of \$1,750 for a mobile kitchen. This check was presented to the National British War Relief Society, 730 Fifth Avenue, New York City. These kitchens are staffed by Americans and go about to feed the people in the wrecked areas. On February 24, 25, 26 the Mobile Kitchen will be on display at Journal Square, Jersey City, N. J.

Mercer County

Reported by Mrs. A. F. Moriconi, Trenton, N. J.

The monthly meeting of the *Woman's Auxiliary to the Mercer County Component Medical Society* was held in the McKinley Hospital, Monday, February 10, at 11 a.m., with thirty-one members present, and Mrs. G. N. J. Sommer, President, presiding.

Dressings were made, luncheon was served at 1 p.m., and business was transacted in the afternoon.

Mrs. James J. McGuire and Mrs. C. C. Chianese were chosen to represent Mercer County at the State meeting in Newark on April 14.

At the next meeting there will be a talk on public relations.

A card party is being planned in the future in order to raise money for the Auxiliary.

Passaic County

Mrs. Joseph E. Mott, Reporter

The regular meeting of the *Woman's Auxiliary to the Passaic County Medical Society* was held January 20, 1941, at the Elmwood Country Club, with Mrs. Alfred D. Meneve, President, presiding, and thirty-nine members present.

Reports were given by the following committees:

Legislation—Mrs. Harry Dawson

Press and Publicity—Mrs. Joseph E. Mott

Membership—Mrs. James S. Gallo

Art and Hobby—Mrs. C. B. Russell

Widows and Orphans—Mrs. Andrew F. McBride

State Bulletin—Mrs. Leslie Taber

New members accepted were:

Mrs. Albert Graeter	Mrs. J. S. Freedman
Mrs. Jacob Averbach	Mrs. H. Levy
Mrs. T. Saberese	Mrs. S. Della Penna
Mrs. A. Simkin	Mrs. J. M. Keating



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PLACE	NAME AND ADDRESS	TELEPHONE
AUDUBON	W. H. Tegler, 315 Atlantic Ave.	Audubon 1037
BAYONNE	Nelson Dittmar, Ph. G., 924 Broadway at 44th St.	Bayonne 3-0406
BELMAR	William T. Lins, 1500 F St., cor. 15th Ave.	Belmar 559
BERNARDSVILLE	Hemmendinger Pharmacy, 12 Mine Brook Rd.	Bernardsville 78
BLOOMFIELD	Nicholas G. Burgess, 50 Broad St.	Bloomfield 2-1006
COLLINGSWOOD	Oliver G. Billings, 760 Haddon Ave.	Collingswood 4034
CRANFORD	J. Walter Seager, 103 Union Ave. N.	Cranford 6-0700
ELIZABETH	Kerner's Prescription Pharmacy, 504 Court St.	Elizabeth 3-9497
HACKENSACK	Gorman-Noble Drug Co., 269 Main St.	Hackensack 2-0660
HARRISON	Squier's Pharmacy, 234 Harrison Ave.	Harrison 6-2127
MONTCLAIR	Wm. J. McNulty, So. Fullerton Ave. & The Crescent	Montclair 2-2014
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NEWARK	Marquler's Pharmacy, Sanford & So. Orange Aves.	Essex 3-7721
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NEW BRUNSWICK	Hoagland's Drug Store, 365 George St.	New Brunswick 49
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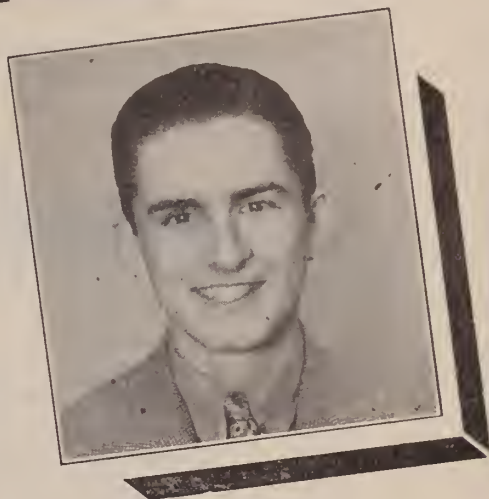
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Hypothetical Combinations	Geyser Water	Hathorn Water	Coesa Water
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Potass. chlorid	361.91	789.54	714.86
Sodium chlorid	2,010.48	8,594.84	4,233.14
Potass. bromid	9.23	160.00	13.90
Potass. iodid	1.10	4.80	1.36
Sodium sulphate	None	None	None
Sod. metaborate	Trace	None	Trace
Sodium nitrate	Trace	Trace	Trace
Sodium nitrite	Trace	Trace	Trace
Sodium bicarb.	2,213.78	424.71	1,331.15
Calcium bicarb.	1,829.14	3,380.84	2,519.74
Barium bicarb.	16.67	25.65	25.00
Strontium bicarb.	Trace	Trace	Trace
Ferrous bicarb.	9.94	40.07	5.86
Magnes. bicarb.	753.89	2,244.88	1,186.57
Alumina	7.14	4.98	6.37
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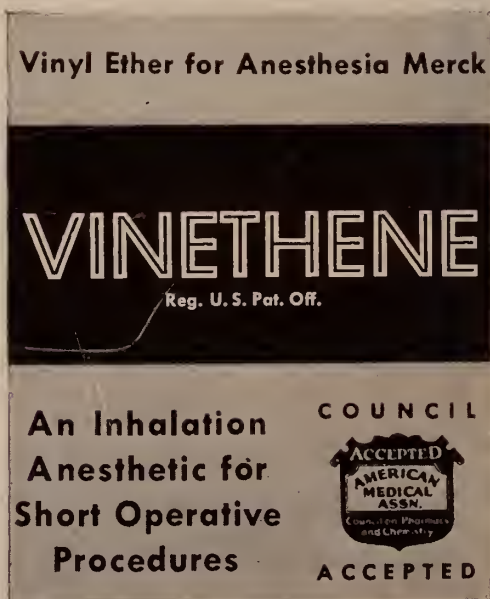
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MAY WE therefore suggest, for your patients who smoke, the protection of Philip Morris—proved* definitely and measurably less irritating to the membranes of the nose and throat.

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Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154— Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60



Q. But, doctor, is it all right to leave the peas I don't eat in an open can?

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The typical dermatitis of pellagra, characterized during its early stages by tenderness and erythema, and subsequently by thickening of the skin, and desquamation, not infrequently involves the lower extremities, especially the anterior aspects of the feet, ankles, legs, and knees.

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Nicotinic acid is pyridine-3-carboxylic acid— $C_6H_5O_2N$. It is recognized as a specific in the treatment of the disease of dogs known as blacktongue and in the treatment of human pellagra.

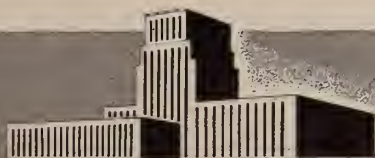
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THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

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EDITORIAL

Health Legislation

With the opening of the 77th Congress and the reconvening of many State Legislatures, numerous proposals for improving the nation's health by legislation have been presented.

Prompted by the President's call for "Wider opportunities for adequate medical care", Senator Wagner of New York has introduced a new National Health Bill, similar in many ways to the one that died in the last Congress. The chief difference between the 1940 act and that of 1941 is in their costs. In the present Bill the amounts have been materially reduced. The State would pay two-thirds of the cost, and the other one-third would be paid out of Federal funds. This is one of the many schemes which has been simmering for some time, and is rapidly reaching the boiling point under the guise of "National Defense".

The idea underlying the legislation, as we of the medical profession know, is that the politicians think the Government should control the distribution of medical care to the entire population; and when this happens, the practice of medicine will be done through a political bureau. Political bosses will make sure that the doctors serve an over-load of patients a day, with no thought as to the type or quality of care they receive.

Compare this new scheme with the traditional American system of private medicine, where the individual chooses his doctor, and has the privilege of consulting him unhurriedly and in an atmosphere of intimate confidence. We all know too well about the free service of the doctors to those unable to pay; and we may be justly proud that for centuries our noble profession has unqualifiedly stood for the treatment of anyone who is ill (or thinks he is), whether or not he could pay for it. The health records of the past few years speak well for the present way of practice, for we rightfully claim the highest expectancy of life ever enjoyed by any nation.

Never has American Medicine, in its economic and social relations to the public, faced a more critical issue than that which now confronts it. Medical services are in the process of rapid changes; and Federal and State legislation is being brought before the public, with the hope that mass public opinion will provide the necessary votes to have it placed on the statute books.

If we are to preserve the unity of the medical profession, we must continue to fight for our economic welfare. We must promote efficiency in medical practice; develop closer and

more friendly relations with all lay organizations; and offer them expert assistance and advice in matters pertaining to health. We should make the lay organizations realize that Federal aid and bureaucratic control will be too big a price for what they will get in the form of medical care. They must be made to feel that lay dictation of medicine is not only unsafe, but is an absurdity; and that the care of the sick should be strictly under the supervision of men scientifically trained in medicine.

A closer coöperation between the medical profession and the laity would go a long way in strengthening the foundations of public opinion that requires better salesmanship on the part of the doctors, and a broader scope of their public relations.

We are facing a real crisis.

Act now!

WATSON B. MORRIS, M.D.,

President.

The 175th Anniversary Meeting

The Annual Meeting Committee has provided a departure from the programs of the past few years in an endeavor to meet the desires and needs of our members.

There will be no specialized section meetings, and the general meetings will afford an opportunity for the general practitioner and specialist alike to benefit, for both must keep abreast of the profession in all fields of medical practice in so far as he can. Recreation is an essential part of our Annual Meeting and more time is provided to enjoy it in various forms. The House of Delegates meetings will be more interesting and shorter, and the social features will center about the President's Banquet and Dance as usual.

The Executive Offices provide technical exhibits and arrange for booths, etc., at a saving, and the scientific exhibits are selected by the Committee.

This is the 175th Anniversary Meeting, and your interest and support at the Annual Meeting will be an indication of the interest and concern of the profession in preserving the essentials developed in our long-continued evolutionary efforts during this period of time. There are many issues of vital importance to be discussed and decided and this will be the chance to have your views heard.

Incidentally, we shall also all have a very good time.

L. A. W.

Leadership

There can be no *dictator* in Organized Medicine. The Board of Trustees is the Executive Body in both the A. M. A. and in the State Societies. Increasingly, the need for a similar executive group is being appreciated and provided in the component county societies.

The President is always a member of these Executive Groups, but even he has but one vote in the final decision. The prestige of his office accords to him at all times respectful

attention, but it is the majority opinion which prevails in the final decision.

The House of Delegates makes the final rules and regulations. Even the Executive Board—the Trustees—can make rulings to govern only until the next meeting of the House of Delegates.

The members of the Board of Trustees accept the responsibility inherent in their election, and serve unhesitatingly, fairly, and consistently in promoting the best interests of the profession.

L. A. W.

ORIGINAL ARTICLES

THE TREATMENT OF PEPTIC ULCER, WITH EMPHASIS ON THE PRECIPITATING FACTORS

By JULIUS GERENDASY, M.D., Elizabeth, N. J.

Read before a joint meeting of the Interne Staffs of the Elizabeth Hospitals, November 1, 1939.

I. DEFINITION

The picture of a round, punched-out, sharply demarcated excavation is typical of a chronic ulcer, no matter whether located in stomach, duodenum, esophagus, or jejunum, or in a Meckle's diverticulum. Only ulceration in the stomach and duodenum will be considered in this paper.

II. ETIOLOGY

Incidence: It is commonly stated that ten per cent of the population is affected.

Cause—unknown. However, it is generally agreed that dilute hydrochloric acid in the stomach produces the chronicity. Of the many theories suggested, a constitutional predisposition is the most useful for the purpose of the discussion which is to follow. A realization and acceptance of the constitutional predisposition to peptic ulceration in an ulcer patient is important from the standpoint of therapeutics because a recurrence of ulceration is likely and the care and treatment by the patient, of himself is a life-time job. That is why we say, "Once an ulcer patient, always an ulcer patient."

If one accepts the constitutional predisposition to ulceration, how can one account for the healing of an ulcer in such an individual? Undoubtedly an ulcer diathesis, alone, is not sufficient. There must be in addition some "precipitating" factor or factors. Therefore, both in looking for the cause, and in the treatment it is better to speak of the *precipitating* factor which brings on the attack, for then we have something to avoid and to treat, and to warn the patient against.

Too frequently, however, the patient and his doctor's attention is focused on the presenting symptom, the ulcer; and after it heals the patient is allowed to revert back to his former habits of living, which again permit the precipitating factor to operate with recurrence of

the ulcer. It is worthy of emphasis, "Do not treat the symptom, treat the patient as a whole." If the constitutional predisposition is the accepted etiological cause of ulcer, it means therapy of the patient is a life-time job, since the diathesis cannot be eradicated. The treatment is to control the precipitating factors in order to keep the patient well. For example, if poor food habits is a precipitating cause (as it often is), he is forced to modify his dietary regime throughout his life. Because food is an excellent neutralizing agent for the hydrochloric acid which prevents the healing of the ulcer, such a patient should eat four or five times a day for the rest of his life. If the above concept is accepted, surgery for the cure of ulcer is never indicated and is of no value. Surgery is indicated only for complications. It is illogical to assume that the predisposition to ulcer can be cured by surgery.

III. MORBID ANATOMY

Similarities and differences in the pathological anatomy of gastric and duodenal ulcer exist. Both types may be acute, or chronic.

The acute form is a small, shallow, thin-floored niche involving the mucous membrane and exposing the muscularis. There is no fibrous reaction.

The chronic ulcer is larger, hard, infiltrated with fibrin, and the adjacent mucous membrane may be puckered. It penetrates the mucous membrane, muscularis and often the serosa. In the latter case perforation is likely to occur.

Chronic ulcers are heavily infiltrated with fibrin deposits, giving the name of *chronic callosous ulcer*. If the ulcer penetrates into the muscularis, the result and outcome differ with the location of the ulcer. An ulcer on the anterior wall of the stomach or duodenum tends to perforate; but on the posterior wall the ulcer tends to penetrate into a vessel and bleed.

The most unfavorable ulcer is on the posterior wall of the duodenum, for it is difficult to heal since it often penetrates into the liver or pancreas. Gastric ulcer is most often associated with a localized gastritis of the hypertrophic type.

No explanation can be given as to why duodenal ulcer, as compared to gastric ulcer, is more common in this country than in European countries; or why more males than females have *duodenal* ulcer, especially in this country, and more women have gastric ulcer.

Location.—Practically all duodenal ulcers occur in the first part of the duodenum, rarely in the second portion. It is claimed that 75 per cent of prepyloric ulcers are potentially malignant. This is important from the standpoint of treatment. In actual practice about one-half of gastric ulcers are on the lesser curvature in the *pars media*.

IV. SYMPTOMS

It is often difficult to differentiate between duodenal and gastric ulcer by the symptoms. However, in chronic peptic ulcer the symptoms may be divided into three groups,—those with regular onset; those with symptoms irregular, or constant; and those with symptoms neither irregular or regular. The regular sequence of food, comfort, pain is more often characteristic of duodenal ulcer while food, comfort, pain, comfort rhythm is characteristic of gastric ulcer. Symptoms that recur regularly the same hour (clocking) for days or weeks suggest peptic ulceration. Pain that comes several hours after a meal and continues to the next meal with relief by food or with vomiting or soda is pathognomonic of ulcer. Occasionally, the expectation of relief from food is misleading especially at the acute onset of the ulcer symptoms. The patient's food may be too coarse or otherwise too irritating to produce relief. It is only with bland foods, especially milk, that relief may be expected. Conversely, a patient afraid to eat his usual meals also suggests ulcer. Pain or epigastric distress requiring the constant use of soda should always suggest organic disease. Tenderness and soreness in the epigastrium with an attack suggests an organic disease.

The location of the epigastric distress is important in differentiating gastric from duodenal ulcer. Pain to the left of the mid-epigastrium suggests gastric ulcer; and to the right of it, a duodenal ulcer. The patient's description of the pain is often difficult to interpret. In this regard the Libman test is of great value. It may also be helpful in differentiating organic from functional disease.

The Libman test gives the degree to which the patient responds to the sensation of pain. The threshold value of pain varies considerably in different people. Pain in the hypersensitive (neurotic, high-strung type) is of questionable value; while pain complained of by a phlegmatic individual is worthy of note. The Libman tests is performed as follows: Exert steady, firm pressure with the thumb on the tip of the mastoid. Then exert pressure similarly on the styloid process at the angle of the jaw. This is performed first on one side, then on the other side. Pressure on the mastoid prepares the patient for the effect of pressure on the styloid. The reaction is as follows:

a. Following pressure on the styloid bone a very sensitive patient cries out, and quickly draws the head away. He is the one who exaggerates his symptoms, and in his case it is difficult to separate the wheat from the chaff.

b. A normally sensitive patient moves the head away and speaks of hurt. His symptoms should be taken at full value.

c. A subsensitive or insensitive individual has no consciousness of pain sensation. He is the one who perforates or bleeds without premonitory symptoms. His complaints are atypical. The location of his distress is atypical. It may be no more than a complaint of fullness in the epigastrium, relieved by food. However, careful history may elicit periodicity and seasonal recurrence. Here is where the Libman test is of its greatest value, for to repeat, typical symptoms are absent and even a slight sensation of organ dysfunction is significant.

V. DIAGNOSIS

There are six methods of making the diagnosis:

1. History.
2. Physical examination.
3. Gastric analysis.

4. X-ray.
5. Gastroscopy.
6. Gastric photography.

1. *History*.—First remember there are ten duodenal ulcer patients to one gastric ulcer. Without repeating what has been said under symptoms, the chief value of a good history is that it may help to differentiate between a functional, and an organic lesion. The Libman test is of value. Also a patient awakened at 2 a. m. with pain, or a patient afraid to eat, or a patient in whom food brings on pain,—all these suggest an organic lesion of the stomach.

The one factor which one may find most helpful is a history of chronicity, intermittency, or periodicity of exacerbation of gastric symptoms, occurring over a period of years. A previous history of gastric distress two or five or ten years prior to the onset of the present attack, lasting from two to four weeks, suggests an ulcer. Onset or recurrence of gastric complaints in Spring and Fall is another factor of importance. A gastric ulcer history is not as clear as a duodenal ulcer and it is more often found unexpectedly. It heals quicker than a duodenal ulcer; also the symptoms are more closely associated with the intake of food. Between the ages of thirty and fifty occur 60 per cent of ulcers.

2. *Physical Examination*.—Tenderness left of the midline suggests gastric ulcer; to the right of the midline, duodenal ulcer. Muscle guarding (spasm) suggests underlying pathology. The habitus of the individual is important. Duodenal ulcer is said to occur more frequently in the asthenic habitus (narrow epigastric angle). It seems, however, to be more common in the sthenic (or wide epigastric angle) type.

3. *Gastric Analysis*.—Where possible, a fractional analysis is preferable to a single extraction. The test usually reveals hyperacidity and hypersecretion. In gastric ulcer, fasting residuum is helpful, especially for microscopic evidence of fresh blood. A blood count for anemia and stool examination for occult blood are other helpful tests. A persistent occult blood in the stool suggests ulcer or malignancy of the stomach.

4. *X-rays*.—The only unqualified x-ray evi-

dence of ulcer is the demonstration of an ulcer crater, or so-called "niche" defect. An ulcer on the lesser or greater curvature of the stomach or duodenum can generally be seen or demonstrated easily. Prepyloric ulcers are generally very small, and because of associated spastic phenomena, are difficult to demonstrate. On the other hand, prepyloric deformities must be differentiated from reflex spasm from a diseased gall-bladder, appendix, or kidney. Fluoroscopy is indispensable in the diagnosis of ulcer.

5. *Gastroscopy* is of value: 1, by revealing an ulcer not seen by other means; 2, the success of treatment can be noted; 3, it differentiates between benign and malignant ulcer; 4, early diagnosis of a small carcinomatous ulcer is possible; 5, it reveals the source of gross hemorrhage; 6, jejunal ulcer can be seen; 7, by noting whether an artificial stoma is working; and 8, diagnosis of gastritis, atrophic or hypertrophic, can be made.

Gastroscopy is of value only in well-trained hands, and is not as simple to perform as one is led to believe by reading the literature. It is quite an ordeal to the patient.

VI. PROGNOSIS

A prognosis should be guarded. "Once an ulcer patient, always an ulcer patient." One never knows when and what may cause a recurrence.

When is an ulcer healed? A fair criterion would be: 1, with the disappearance of the "niche" and absence of gross and occult blood in gastric contents and stool; 2, absence of pain and tenderness; 3, it is generally agreed that it takes about six weeks to heal an ulcer. Crohn found that a gastric niche occasionally disappears in seven to ten days.

The healing of an ulcer and the relief of symptoms do not go hand in hand. Relief from symptoms may come in a few days, especially if the patient is put to bed. In fact, bed rest will often differentiate an uncomplicated ulcer from a complicated one. It is well to speak of the *successful management* of ulcer patients, and not the cure. The life history of ulcer ends with the life of the patient. The successful medical management produces a remission and

prevents recurrence, and that is all one may hope to accomplish.

VII. COMPLICATIONS

Complications occur in 30 per cent of cases seen at the Mayo Clinic. Major complications are perforation, obstruction, hemorrhage, hour-glass deformity, and malignant transformation of the ulcer.

1. Perforation usually occurs only in the chronic ulcer. The description is classical. The patient is in agony, the face pale, haggard, and anxious, with cold sweat on the face; holds himself rigid and motionless, and breaths with the chest while the diaphragm is fixed. The temperature is subnormal, and the abdomen in a board-like rigidity. There is marked tenderness in the epigastrium.

2. *Hemorrhage* may be concealed, slow but progressive, and causing severe secondary anemia; or it may be sudden and profuse, and in that case, pallor, cold sweat and shock are the predominant signs. It should be a rule that all such cases receive immediate hospitalization. A digital rectal examination is valuable. Tarry stool on the finger cot immediately suggests a gross hemorrhage. It will often make the diagnosis in obscure cases. A not infallible rule is that in duodenal ulcer it may only be melena (dark, pitchy stools) and no hematemesis; while in gastric ulcer both hematemesis and melena may occur.

3. *Obstruction* is due to contracted scar of an ulcer. Vomiting of stale, sour food, poorly digested, often induced for relief of intractable pain in spite of adequate treatment, suggests organic obstruction. A prolonged intermittent history (years) of gastric distress is confirmatory.

4. *Cancer transformation* occurs only in gastric ulcers, and in about five per cent of them.

VIII. TREATMENT

A. Heretofore, too much emphasis has been placed on drug therapy and the relief of symptoms. Much more important are the factors about to be discussed. It should be remembered that ulcer symptoms are often self-limited, and may subside with very little therapy. The important problem is to prevent a recurrence. In

this connection, the physician and the patient should be familiar with the following *precipitating factors* conducive to ulcer exacerbation.

a. *Psychogenic* (emotion).—This term is preferable to the oft-used "neurogenic" factor, since it is more descriptive and is one of the most outstanding causes in the recurrence of the ulcer. Under this are included, 1, illness in family; 2, financial worries; 3, poor home environment; 4, excitement, anger, worry, grief, and too much social activity.

b. *Food Factors*.—The following foods are harmful to the patient and a cause of gastric trauma: Alcohol, tobacco, coarse vegetables, soup extracts, sweets and spices, sour food (pickles, vinegar), whole wheat and high residue laxative products, and foods very hot or very cold.

c. *Fatigue*, long hours of work, exhausting work, night and day work.

d. *Infection*, particularly of the upper respiratory tract, is frequently conducive to recurrence. Infection causes gastritis, which is the precursor of ulcer. Localized infection, such as that by streptococci of the gastric or duodenal mucus membrane, should be considered a precipitating factor and not an etiological factor in the production of ulcer. Tissue susceptibility on a constitutional basis may be an etiological factor. Clinically, reactivation or the occurrence of ulcer in the Fall when infection of the upper respiratory is present is quite common.

e. *Vitamin deficiency*, especially in vitamin B and C. The lack of the C vitamin may cause a tendency to hemorrhage. These vitamins are especially important where a prolonged restricted diet is used.

f. *Allergy* to food may be a precipitating factor by producing edema of the mucous membrane, and spasm of the smooth muscles in the stomach. This results in ischemia and peptic digestion, followed by ulceration. Allergy can be suspected by eliciting a history of hives, purpura, eczema, hay fever, or asthma. The foods most commonly responsible are milk, eggs, and whole-wheat products. The elimination from the diet of the causative factor will cause remission in many ulcer cases intractable to treatment.

B. THERAPY

Simplicity should be the rule in the treatment of ulcer patients, whether hospitalized or ambulatory, for the treatment is prolonged. The patient should be under the physician's close observation for a minimum of six months, but preferably a year. The treatment of the psychogenic factors is important particularly in these troubled times. Here is where the physician's personality plays an important rôle. He should remember that he cannot treat the body unless he also treats the mind. It is his duty to educate the patient to the realization that, because there is a hereditary trend to ulcer formation, he should accept this and try to live within the limit of his disability. For example, if he has 25 per cent disability, he is left with 75 per cent of health and should live within this rating.

C. DIET

The Sippy regime of hourly milk and cream feedings is still the best treatment; then gradual additions of cereal and eggs and other dairy products. Bread should not be given until the fourth week; and meat about the sixth week. The early use of orange juice or grapefruit juice for their vitamin content is to be stressed. The future, or maintenance, diet should be bland, and contain all the elements necessary for a well-balance diet. It should conform as much as possible to the likes and dislikes of the patient according to his racial characteristics. For this reason the physician should be familiar with dietetics, since printed forms have no practical value. Also the precipitating food factors previously mentioned should be stressed.

D. DRUGS

Alkaline Powders.—There is much evidence that complete neutralization of the gastric contents is undesirable, chiefly because it is followed by a rise in the free acid level higher than existed before alkalization. There is also the danger of alkalosis. Likewise renal calculi show an increased growth in patients subjected to prolonged alkalization. In acute cases the use of a mixture of magnesium ponderosa and bismuth subnitrate, each one part with eight parts sodium bicarbonate given in

one-half dram doses, after each of the usual six feedings may be prescribed.

Neutral Powders.—Colloidal aluminum hydroxide (amphojel) and magnesium trisilicate (trimax) are now extensively used to replace alkaline powders in buffering gastric acidity without having the untoward effects of alkaline powders. These do not appear to interfere with the activity of the digestive enzymes. They should be continued for several months, a dram before each of the main meals. Unfortunately, neutral powders tends to cause severe constipation.

Gastric Mucin.—Mucin furnishes the mucus which the patient lacks because of faulty metabolism. Doses of four to eight grams, in four daily doses with frequent feedings, and the administration of antispasmodics, appear to help certain intractible cases and reduce recurrence better than most other treatments. The cost is a factor.

Histidine (larostodin).—Gastric ulcer gives the best response to this drug clinically as well as roentgenologically. Younger patients and those whose symptoms are relatively of short duration respond better than do those who have had ulcer symptoms previously, or have been suffering for a long time with only intermittent relief. Its effect may be psychogenic.

Vaccine and foreign proteins occasionally help where other means do not. The latter is especially useful in relieving pain.

Belladonna and atropine are useful drugs, and act by relieving spasm and perhaps by decreasing acid secretion.

Sedatives.—Bromides and luminal are frequently indicated and are of use especially for the emotional type.

Rest, especially bed rest, is a very important part of the treatment of the ulcer patient. In gastric ulcer cases it should be the rule. It is conducive to mental, physical, and nervous well-being. In the ambulatory cases, patients are urged to rest from fourteen to sixteen hours a day, and to remain in bed over the week-end, particularly during the acute phase.

Conclusion: Since the true etiology of peptic ulceration is unknown, emphasis is placed, in this paper, on the predisposing factors and their prevention.

SYPHILIS OF THE THORACIC AORTA

By JOSEPH E. HIGI, M.D., Newark, N. J.

Delivered under the auspices of the New Jersey Department of Health, at six centers—Orange, Paterson, Morristown, Trenton, Neptune, and Camden—on successive Wednesdays, beginning September 25, 1940, as a part of a refresher course in syphilis for physicians of New Jersey.

Syphilis of the thoracic aorta is essentially a disease of middle life. It is about three times as common in the Negro as in the white, and most prevalent of all in the colored male.

About 10 per cent of untreated, or poorly treated, syphilitics eventually develop clinical evidence of syphilitic aortitis; and it is estimated that 20,000 persons die annually in the United States from this complication.

The best treatment is *preventive* treatment. A syphilitic receiving standard therapy early in the disease is practically assured of escaping the more serious forms of aortitis.

PATHWAY TO THE AORTA

After the spirochetemia of the early stages subsides, the mediastinal lymph nodes become an important spirochetal reservoir. The opulent lymphatic plexus about the base of the aorta empties into these glands; and, by retrograde lymph flow, the spirochete has quantitative access to the lymph spaces around the vasa vasorum of the aorta.² The process spreads along these nutrient blood vessels, involving first the adventitia, then the medial coat of the aorta; and, in an occasional case, may ulcerate through the intima, but this latter phenomenon, however, is very rare.

Unfortunately, aside from almost continuous exposure to the spirochete, the tissues of the aorta are prone to develop varying degrees of specific hypersensitivity to the syphilitic virus.

ALLERGIC FACTORS

Not all tissues of the body need necessarily react to the *treponema pallidum*; and in some cases those tissues which are most commonly the seats of reaction, i. e., the skin, the vascular, the osseous and the nervous systems,—may singly or in combination be anergic, that is, non-reacting. As far as these non-reacting tissues are concerned, the spirochete is a saprophyte.

In a tissue which does react, the great immunologic secondary reaction may result in complete immunity; or this immunity may be achieved only after repeated relapse and remission. It is conceivable that, by divers combinations of anergic and immune phenomena, many or all the tissues of the body may be protected against the syphilitic virus, and a spontaneous "cure" ensue.

On the other hand, certain of the reacting tissues may never learn to fashion the proper immunologic keys; or, if they do so, the degree of resistance may be insufficient to protect against subsequent quantitative exposure. These tissues with incomplete or altered immune reactions may, on further exposure to the syphilitic substances, manifest various grades of altered reactivity.

In secondary syphilis the lesions may teem with spirochetes, and yet these lesions heal almost invariably without tissue destruction. In tertiary lesions tremendous tissue reactions with widespread tissue destruction may be elicited by only a few spirochetes. These tertiary lesions are evidence of an altered reactivity on the part of the tissues to a substance to which they have had adequate previous exposure. Moreover, this hypersensitivity is specific.

PATHOLOGY

The tertiary lesion is a predominantly vascular process. The cellular infiltrate is perivascular, and is composed of plasma cells, lymphocytes, and fibroblasts. Giant cells and epithelioid cells are sometimes present. The cellular mass is abundantly supplied with newly formed capillaries.

In the preëxisting blood vessels an *obliterative endarteritis* ensues, partly due to the pressure of the exudate externally, and partly due to the proliferation of the intima. The process involves the internal and external coats of the blood vessels, but spares the media. In the

aorta and larger arteries the media is involved secondarily through the vasa vasorum.

Tertiary lesions may heal by fibrosis; or the obliterative endarteritis may cause necrosis of the central portion, with a resultant gumma. It is customary to regard fibroses and gumma as two distinct and separate processes, but this is not strictly true. Both reactions represent attempts to heal by supplanting the syphilitic infiltration with a new connective tissue; and in the case of fibroses the reaction achieves its goal; but in gumma it has failed.

Both processes may be seen in the same tissue, and almost every gumma shows some degree of successful fibrosis, the necrotic central area merging gradually into a marginal, living capsule of connective tissue.

In the aortic tissues, fibrosis is the usual expression of late syphilis.

UNCOMPLICATED SYPHILITIC AORTITIS

This term means that syphilitic changes are present in the wall of the aorta, but these changes have not progressed to the stage of aneurysm, aortic regurgitation, or atresia of the coronary orifices.

As the fibrosis spreads, certain signs and symptoms may follow.

Among the first of these is a change in the timbre of the second aortic sound. This alteration is described as tympanitic, bell-like, or tambour, and is supposedly due to the changed acoustics evoked by the closure of the aortic valve in a tube more thickened and rigid than normal.

To examiners with a highly developed sense of pitch the sign is very valuable. A sound which closely simulates it may be produced by hypertension or by any condition, such as mitral stenoses or left heart failure, which increases the tension in the pulmonary artery.

The weakening of the walls of the first portion of the aorta may produce some degree of dilatation. Aortic distention may be disclosed by percussion, but by far the most reliable method of detecting the change is an x-ray or fluoroscopic examination of the cardio-aortic stripe.

The upper normal width of the great vessel shadow on a six-foot film is generally considered to be six centimeters. A definite increase above this figure, in a known syphilitic under fifty years of age, without hypertension, offers the most valuable single sign in establishing the diagnosis of syphilitic aortitis. Roentgen-

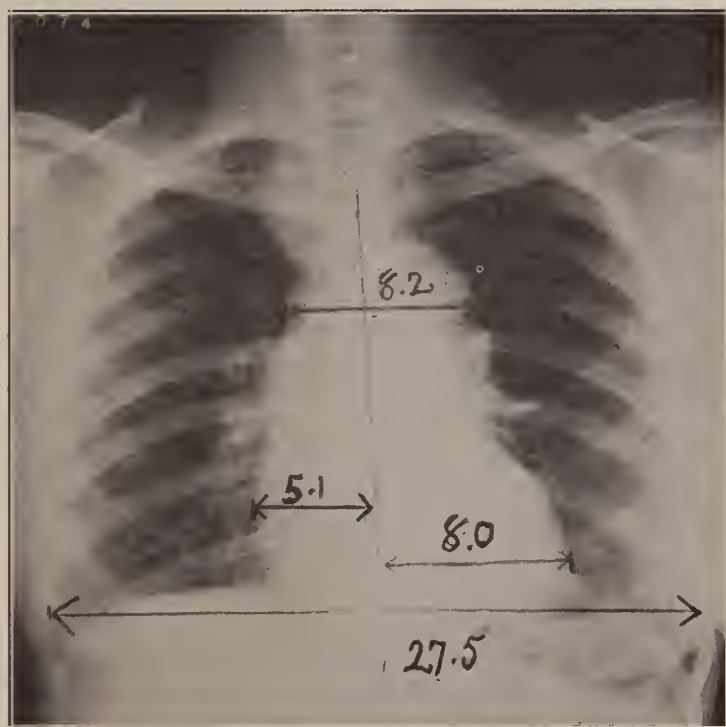


FIG. 1.—UNCOMPLICATED SYPHILITIC AORTITIS

Case E. B. Colored female, aged 35 years.
(The numerals indicate centimeters on the x-ray plate.)

Blood Wassermann: Positive.

Spinal fluid: Negative.

The great vessel shadow is definitely widened, measuring 8.2 cms. The generally accepted upper limit of normal is 6 cms. The transverse diameter of the heart shows no enlargement; this measurement, 13.1 cms. (5.1 cms. plus 8 cms.), being less than one-half the internal diameter (27.5 cms.) of the chest.

Patient complains of substernal pain and paroxysmal dyspnea. The second aortic sound is tympanitic in character. The blood pressure is normal.

ologic examination should include the oblique, as well as the antero-posterior plane. (A six-foot film is one taken with the focal spot of the x-ray tube at a distance of six feet from the film, with the chest in contact with the cassette.)

Various degrees of chest discomfort may be experienced with or without atresia of the coronary orifices. The sensation may be pain, ache, pressure, or tension; and is usually substernal, but it may be confined to either pectoral area or the left shoulder. It may or may not radiate; in fact, the only thing characteristic of these chest sensations is variability.

"Sleep start" or "sleep drop" is a common complaint of patients with aortitis. It is usually experienced as the patient is dozing, and may be repeated many times before deep sleep is attained. The sudden startled awakening is preceded in some cases by a sensation of falling; in others it is described as a feeling of expanding fullness or heaviness in the head which causes the individual to awaken precipitously following a forced expiration. These nightmarish episodes may be accompanied by a brief period of apnea in which the individual struggles for breath. It may gradually merge into paroxysmal dyspnea, and probably has the same significance.

The Coöperative Clinical Group lists the following signs and symptoms of uncomplicated syphilitic aortitis:¹

1. Tele-roentgenographic and fluoroscopic evidence of aortic dilatation. (X-ray tube six feet from the body.)
2. A tympanic, bell-like, tambour accentuation of the aortic second sound.
3. A history of circulatory embarrassment.
4. Increased retromanubrial dullness.
5. Progressive cardiac failure.
6. Substernal pain.
7. Paroxysmal dyspnea.

The combination of any three of these signs and symptoms in a syphilitic under fifty years of age, free from hypertension or mitral disease, is strong evidence for the diagnosis of uncomplicated syphilitic aortitis; and the presence of any two of them renders the diagnosis probable.¹

Even in clinics with ample reference facilities and access to x-ray services, the diagnosis

of uncomplicated syphilitic aortitis is a difficult one to establish.

The wide discrepancy between clinical diagnoses and autopsy findings in uncomplicated aortitis is not without foundation. The safest procedure is to treat every case of late syphilis as though syphilitic aortitis were present. This treatment should consist of a long preliminary course of bismuth (12-14 weeks) before any arsenical is given. The total amount of treatment should correspond to that advocated for the treatment of early syphilis, i. e., 60 bismuth, and 30 arsenic injections.

SYPHILITIC AORTITIS WITH ATRESIA OF CORONARY ORIFICES

Coronary atresia is essentially due to the process in the wall of the aorta which casually envelops the coronary orifices during the course of its progression.²

The syphilitic infiltration rarely involves the coronary arteries distal to the aortic wall. In older patients concomittent atheromatous or sclerotic changes may be present in the coronaries in the same degree of frequency with which these changes occur in non-syphilitics of the same age.

This condition may be present without causing alarming signs or symptoms and almost complete atresia of the mouths of the coronaries may be found at autopsy in individuals who have led fairly active lives without any marked cardiac manifestations. Sudden death and subsequent post mortem findings may yield the first knowledge of the existence of the condition.

The reason for this seeming paradox may be because the condition develops slowly and most individuals with aortic syphilis are in a period of life during which the circulatory system still retains its anastomatic versatility.

The various avenues for intra- and extra-cardiac anastomoses are:

1. Between branches of the same, and the opposite coronary.
2. Between the coronary circulation (via the Thebesian vessels and myocardial sinuoids) and the cavities of the heart.³
3. Extracardiac communications, between the auricular twigs of the coronaries and the

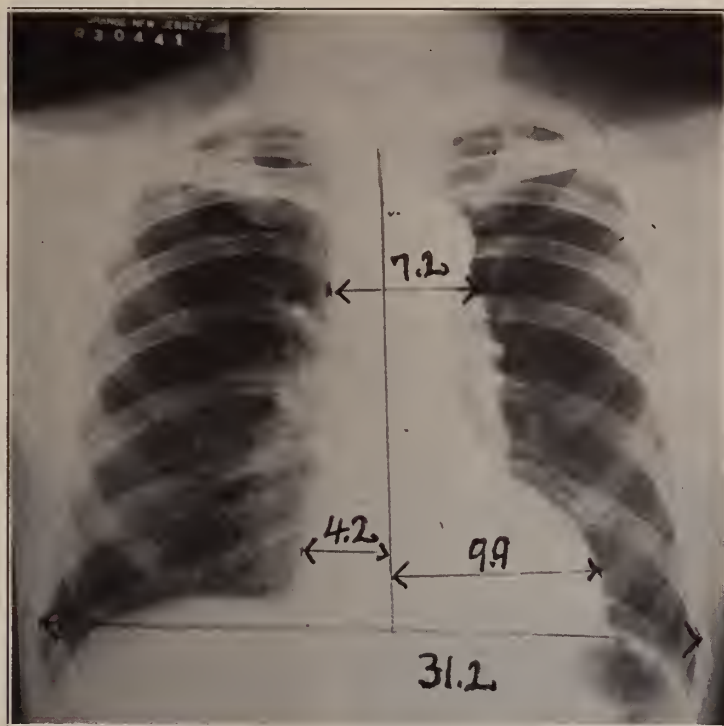


FIG. 2.—ARTERIOSCLEROTIC AORTA

Case J. D. White male, aged 65.

(The numerals indicate centimeters on the x-ray plate.)

Blood Wassermann: Positive.

Spinal fluid Wassermann: Positive.

The aorta is dilated, elongated and somewhat tortuous with a prominent aortic knob. The heart shadow is within normal limits. It is always difficult and in most cases impossible to differentiate uncomplicated syphilitic aortitis from an arteriosclerotic aorta on x-ray examination alone. The diagnosis of either is based upon presumptive evidence such as the age of the patient and concomitant signs and symptoms. In older syphilitics it is not uncommon to find both processes in the aorta at autopsy.

internal mammary, pericardial, bronchial, phrenic, and oesophageal branches of the aorta.⁴

The importance of these extracardiac anastomoses has been demonstrated in experimental animals in whom the coronaries may be gradually clamped until the vessels are almost completely occluded (85 per cent) without serious signs of myocardial anoxia developing.⁵ These laboratory conditions are probably approximated in the production of syphilitic stenoses of the coronary apertures, the slow development permitting a high degree of collateral readjustment. For this reason it is unusual for persons with this condition, unless sclerosis of the coronaries also exists, to experience a typical anginal seizure. The distress, when

present, is usually a more or less constant substernal tension or ache which may or may not radiate. A peculiar aspect of this substernal distress is that the individual may be more conscious of it while at rest and relaxed than when engaged in mild muscular activity, the probable reason being that with the rise of diastolic pressure in the aorta during exercise the inflow through the narrowed coronary openings is enhanced.

When aortitis with stenoses of the coronary orifices is suspected, treatment should be inaugurated with the greatest caution. The normal course of this complication is one of rather slow development, giving sufficient time, in most cases, for life-saving anastomoses to be established. Too vigorous treatment may rob the individual of even this last chance, for the sudden healing followed by scarring deformity may result in a higher grade of stenoses and in a shorter time than if no treatment at all were given.

A quarter-dollar-sized tertiary syphilide in an infiltrative or granulomatous stage on the arm or leg may be attacked enthusiastically and quickly melted away and the resultant scare will involve no vital structures. The judicious handling of a similar plaque at the base of the aorta, encircling or impinging on the coronary orifices, may mean the difference between long life and sudden death.

When treating syphilitic aortitis, one should constantly attempt to visualize the possible extent and location, the possible stage of development, and the possible evil consequences which may follow if the lesion is attacked too intensively with anti-syphilitic drugs.

Treatment should be instituted with a heavy

metal, usually about one-quarter of the average dose, and gradually increased from week to week until the full dose is given. After three to four months of bismuth therapy, the arsenicals may be used, beginning with neoarsphenamine gm. 0.05, and gradually increasing the dosage until gm. 0.3 has been reached.

SYPHILITIC AORTITIS WITH AORTIC REGURGITATION

As in the involvement of the coronary orifices, aortic regurgitation is primarily due to the extension of the process in the aortic wall. The subintimal undermining and the widening of the commissures of the aortic valve cause a separation of the cusps, with a resultant incompetency of the valve. The thickening, curling, and retraction of the free edges of the valve

leaflets is secondary, and is due to the mechanical factors of the regurgitant stream.²

In order to compensate for this regurgitant flow, the left ventricle dilates; and in order to eject a greater amount of blood with greater force against the back flow, the muscle hypertrophies. This stretching and thickening of the left ventricle is the outstanding feature of aortic regurgitation.

The increased contractile energy is greatest during the first half of systole, and falls rapidly during the latter half. The high initial tension stimulates the depressor fibers in the arch of the aorta, and reflex peripheral vasodilatation takes place. The sudden high tension is then followed by a sharp fall, partially due to the rapid loss of pressure during the later phases of systole, and partially due to the arterial system emptying quickly in two

directions simultaneously, — through the unclosed aortic orifice on one end, and the wide open peripheral sluices on the other.

The sudden high pressure followed by the sharp fall accounts for the Corrigan, or water hammer, pulse. The same mechanism also produces the capillary pulsations and high pulse pressure. The hypertrophied heart muscle is further embarrassed by the lessened coronary inflow caused by the fall in the diastolic pressure in the aorta.

Life expectancy depends upon the extent of valvular damage and the innate capacity of the individual heart fibers to undergo lengthening and hypertrophy while still maintaining tone.

Generally speaking, a full-blown aortic regurgitation is the most serious of all the complications of late syphilis; and once the condition is established, death usually ensues in two to four years.

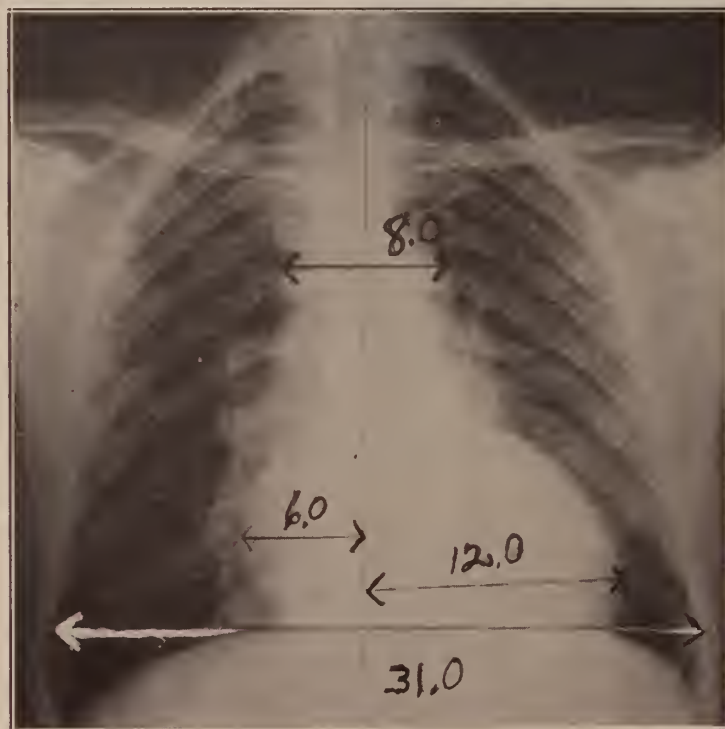


FIG. 3.—SYPHILITIC AORTITIS WITH AORTIC REGURGITATION

Case I. B. Colored male, aged 56 years.

(The numerals indicate centimeters on the x-ray plate.)

Blood Wassermann: Positive.

Spinal fluid Wassermann: Positive.

The great vessel shadow is widened. The heart, especially the left ventricle, is markedly enlarged. Diastolic murmur at base and water hammer pulse. B. P. 170/20. Approximately 30 per cent to 40 per cent of aortitis cases have a concomitant C. N. S. lues.

A long preliminary bismuth course, beginning with one-half the usual dose, should precede arsenical therapy. The dosage of the arsenicals should not exceed a dose corresponding to neoarsphenamine gm. 0.3.

SYPHILITIC AORTITIS WITH ANEURYSM

As the infiltration and fibrosis of the aorta become more diffuse, the weakened wall may give way in localized areas. Saccular aneurysms thus produced are dependent upon intra-aortic diastolic, not systolic, pressure. During systole the aortic walls are contracted, and offer active resistance to lateral stretching. It

is the constant lateral pressure exerted during diastole, especially the late phases of diastole when the weakened fibrotic organ is relaxed, which finally causes the ballooning.

The production of aneurysm depends upon adequate diastolic pressure; and this in turn demands a competent aortic valve so that aneurysm rarely ensues after a fully-developed aortic regurgitation. The converse is not true, however; and after aneurysm has been established, the infiltration may spread inferiorly and involve the aortic commissures, superimposing regurgitation upon aneurysm.

The signs, symptoms, and prognoses depend upon the location, size, and type of the aneurysm.

Aneurysm of the ascending arch is referred to as the *aneurysm of physical signs*. This type may attain a large size without producing great discomfort. It usually extends upward, forward, and to the right; and because of its proximity to the anterior chest wall, it is more easily detected by inspection and percussion than aneurysms of the arch or descending aorta.

The arch of the aorta is the most frequent site for saccular dilatation; and here it is called the *aneurysm of symptoms*. Impingement upon the cervical sympathetics may result in unilateral sweating and dilatation of the pupil. Pressure on the recurrent laryngeal nerve may cause hoarseness or aphonia. Pulsations transmitted to the left bronchus as it dips beneath the aortic arch gives rise to tracheal tug; and compression of the bronchus may result in atelectasis. Erosion of the smaller rami of the bronchi may cause hemoptysis; and symptoms of bronchitis may be present almost continuously.

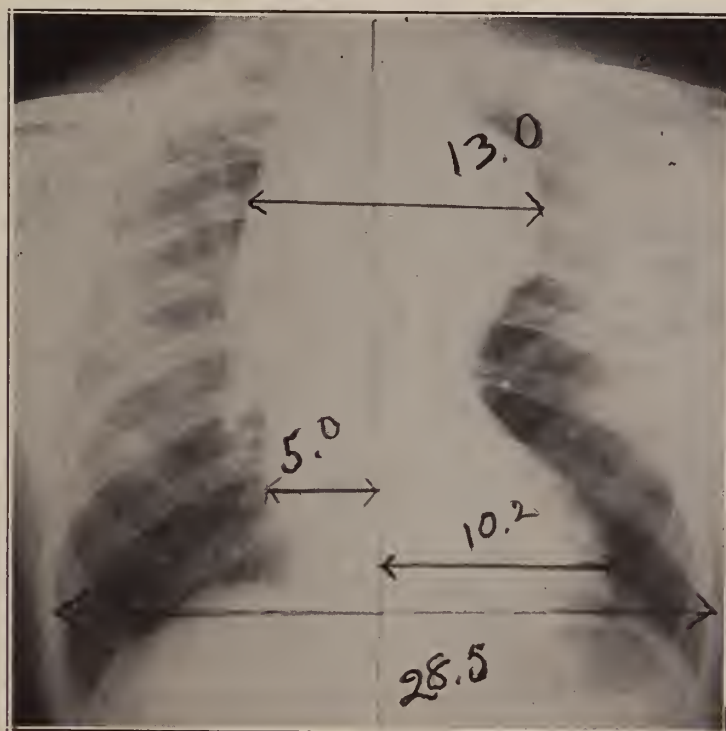


FIG. 4.—SYPHILITIC AORTITIS WITH AORTIC ANEURYSM

Case J. B. Colored male, aged 33 years.
(The numerals indicate centimeters on the x-ray plate.)

Blood Wassermann: Positive.
Spinal fluid Wassermann: Positive.

A large aneurysm is present in the aortic arch. The heart is somewhat enlarged, which is rather unusual with aneurysms uncomplicated by hypertension or aortic regurgitation.

There is normally an interval of 20 to 30 years between the initial infection and the development of aneurysm.

This patient received abortive treatment, consisting of six injections of neosalvarsan, in the seronegative primary stage of syphilis. Six years later he was hospitalized with a right-sided hemiplegia, a positive spinal fluid and the above aneurysm. Inadequate treatment before the immunizing secondary stage has been consummated is much worse than no treatment at all.

Aneurysms of the descending portion of the thoracic aorta are relatively infrequent, and are usually without symptoms, unless pressure is exerted on the spinal nerve roots. When pressure upon these structures exists, all degrees of confusing, referred pain may be present. The diagnosis is generally made by x-ray or fluoroscopic examination.

Due to the resolution of the periaortic infiltration under treatment, the aneurysm may expand in spite of symptomatic relief. The seemingly alarming phenomenon is not a contraindication for specific treatment.

Unless the aneurysm is complicated by hy-

pertension, or aortic regurgitation, or rheumatism, the heart remains fairly normal.

Treatment may be given in the same manner as advised for aortic regurgitation.

SYPHILIS OF HEART MUSCLE

Whether primary syphilis of the heart muscle occurs, or whether myocardial changes are always secondary to aortic lesions, is a moot question and has been a point of contention among pathologists for years.

The general opinion among clinicians is that a primary luetic myocarditis of sufficient extent to give rise to signs and symptoms is a very uncommon occurrence.

SUMMARY

1. Approximately ten per cent of poorly treated or untreated syphilitics eventually develop clinical aortitis.

2. Adequate treatment (30 arsenicals and 60 bismuth injections by the alternating continuous plan of therapy) of early syphilis (first four years of disease) will eliminate the possibility of the development of this complication in practically all cases.

3. When uncomplicated syphilitic aortitis is diagnosed, treatment should be inaugurated with a long preliminary course of bismuth (12-14 injections), and then the standard treatment advocated for early syphilis.

4. When the more serious complications are present, i. e., aortic regurgitation, aneurysm or

atresia of the coronary orifices, treatment should be started with extreme caution with fractional bismuth dosage which is gradually increased to full dosage. After a long preliminary bismuth course arsenicals may be used. The initial amount of arsenic may be one-tenth to one-fifth of the normal dosage and gradually increased until a maximum of about one-half the normal dose is attained. Treatment should extend over a period of one and a half to two years, with subsequent life-time observation if possible.

Both the total amount and the individual dose of arsphenamine must be controlled, since too much arsenic is as bad as none at all. The total number of doses of an arsenical probably should not exceed twenty-five.¹

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MENTAL HYGIENE AND THE GENERAL HOSPITAL

By HENRY A. DAVIDSON, M.D., Newark, N. J.

Read before the New Jersey Hospital Association in Trenton on January 26, 1940.

Service to the community! A general workshop of health and hygiene! These are attractive phrases that every hospital administrator likes to hang in his elevators and emblazon in his annual reports. Yet there can be no adequate community service, no fully equipped hygienic workshop, so long as general hospitals cold-shoulder that large and unfortunate fragment of the population that needs *mental* hygiene as much as *physical* hygiene.

In the first place, why is mental hygiene any of the business of the Hospital Association? Your retort is to toss the ball back to the State and county hospitals, to say that it's a specialized job for which general hospitals have no facilities. When you say that, you evade part of your responsibility.

FIELD OF MENTAL HYGIENE

You see, psychiatry has outgrown its original frontiers. The gimlet-eyed alienist who strokes his beard and pigeon-holes a madman with some long Latin label still roams the wards of mental hospitals in some States,—but not in New Jersey. The psychiatrist here believes that he has something to offer not only to the insane, but also to the *neurotic*; not only to the neurotic, but also to the misfit, the unhappy adult, the problem-bearing child, and the emotionally-disturbed wherever he finds him. And we think that mental hygiene has a promise as bright as the performance already credited to physical hygiene. Tooth-brushes and proper posture do help people remain *physically* well. And adjustment to early emotional problems should help people remain *mentally* well.

EMOTIONAL PROBLEMS IN GENERAL HOSPITALS

General hospitals are, you say, for the *physically sick* only. But you make a spurious distinction, for Nature draws no sharp line between body and mind. A broken leg means something emotionally to one patient; and something quite different to another. Every

disease, accident, operation,—in fact, every human organ,—has its emotional overtones. Not only this, but probably 15 or 20 per cent of the patients in general hospitals present primarily neuropsychiatric problems. And secondary psychiatric implications flow out of every physically sick human being. The general hospital can not honestly advertise itself as a temple of healing unless it shoulders something of the mental as well as the physical fraction of the problem.

Why, then, should a general hospital have a stake in mental hygiene? I have already mentioned one reason—*its obligation to treat sickness*.

A second reason is that such a program will help educate the medical staff in the mental hygiene implications of disease, and thus allow the hospital to contribute to its number two function—that of being an *educational center for the profession*.

A third benefit is that it will gear the hospital into other community agencies that overlap the mental hygiene field,—the courts, the social agencies, the government. And such an integration can only emphasize the value of the hospital to its community.

Fourth, I think the general hospital has a subtle service to perform in *removing the stigma from mental disorder*. The emotionally upset man or woman who flees from the wierd implications of "insane asylum" or "psychiatric clinic" feels more comfortable at going to a general hospital. Nothing will do more towards removing the stigma from mental disorder than associating it with pneumonia and appendicitis, which our general hospitals have made quite respectable.

It is important to *keep the family doctor in the driver's seat for all health problems*. The hospital is his ally in this project. And by encouraging mental hygiene in the general hospital, the institution does its part towards maintaining this central position for the family doctor.

OBJECTIONS TO MENTAL HYGIENE

Let me anticipate your objections. First, you feel that expensive, novel equipment may be needed. This is only an imaginary hurdle, for the type of patient I am thinking of needs no special equipment.

Second, you fear that these patients, whether in clinic or ward, may be the bull in your china shop, and pierce the quiet hospital air with horrible screams and mad ravings. This, too, is an erroneous, if picturesque, misconception. Most mental patients are quiet and well behaved. And we are not asking you to house delirious manics, or offer out-patient facilities to wild catatonics. No, we ask only that the quiet neurotic, the unhappy child, the ambulatory anxiety-patient, the vocational misfit, and other noiseless sufferers from emotional conflict be offered your hospitality.

Finally, you protest that the general hospital does not have enough psychiatrically trained doctors. But if you keep sitting on the trap-door to training, they never will get through. This is your chance to open it.

MENTAL HYGIENE IN NEW JERSEY HOSPITALS

And now let's look at the brass tacks. Of the general hospitals in New Jersey, twenty-five have mental hygiene clinics supplied by State or county hospitals. Seven have psychiatric clinics manned by their own staff. Fifty-two are devoid of any special mental hygiene or psychiatric services.

The twenty-five hospitals which house State or county clinics are rendering a valuable community service. But they do not discharge the obligation of the hospitals. After all, the community and the medical profession see these agencies as *State or county units*. They do not credit the *hospital* with rendering the service. The very fact that the clinic swings in its own private orbit independent of the hospital tends to emphasize the isolation of mental hygiene from general health; whereas truth lies in the other direction. What happens is that the clinic personnel slips into the hospital, secludes itself in a corner, does its job, and quietly fades out, making really no impression on the medical staff, or the hospital administration.

Here is a whole staff of doctors craving for some understanding of mental hygiene factors in disease; there is a team of specialists who can give them this training. They are in the same building, but they never meet. This is a criminal waste of an educational resource. What are we going to do about it?

The first step, I think, should be an effort to have that psychiatrist identify himself more with the hospital. To this end he should be urged to do two things: 1, to visit in-patients; 2, to speak at staff meetings.

Possibly this plan will not work because the same psychiatrist has to serve a half-dozen other hospitals, and can't come in for these extra services. But, at least, *he ought to be asked*. Where these arrangements *can* be made, they will enormously enrich the institution. If they *can't* be made, the hospital should encourage some member of its own staff to attach himself as an assistant in the mental hygiene clinic. He may be a young doctor, fired with enthusiasm for a growing specialty, possibly hoping to enter it himself; or he may be an older doctor, mellowed by his long experience with human beings. In any event, he can become part of that clinic, just as he might join a pediatric or surgery clinic.

You fear that an untrained doctor may do more harm than good? I don't think so. After all, other clinics are manned that way. Almost every unspecialized doctor starts to work in a clinic under the direction of a trained chief; and psychiatry is not so esoteric that you have to know a special password to get by the door.

Now what are the advantages of this set-up? For one thing, the volunteer assistant becomes a *liaison between mental hygiene and general medicine*,—between the special clinic and the general staff. He begins to carry the orientation which he learns at the clinic into his approach to the wards. He is a ferment to stir up a fresh point of view among the doctors.

Second, the psychiatrist ties mental hygiene into the hospital; and conversely, he channels general medicine into the mental hygiene clinic. He becomes the viaduct that bridges the unnecessary gulf between mental hygiene and physical hygiene. As time marches on, increments of experience begin to equip him more

and more to interpret and handle the mentally disturbed, until eventually we turn out a *good general practitioner with a solid mental hygiene orientation*. The dream of treating the patient as a whole, instead of his separate organs, begins to assume reality.

CO-ORDINATING GOVERNMENT AND HOSPITAL CLINICS

How about the hospitals that have their own trained neurologists and psychiatrists? Most of these institutions also have State or county clinics hovering around the periphery of the out-patient department. Here you will find an amazing example of disintegration. The hospital's own neurologic or psychiatric clinic flows in one stream, the State clinic in another. If the hospital administration will meet with the government clinic, it should be possible to integrate these two clinics so that they work together instead of separately, and thus bring into the general hospital all the advantages I have already enumerated. And the hospital's own psychiatrist ought to be encouraged to take active part in staff meetings; and to review the mental hygiene implications of physical disease as presented at conferences and clinical meetings.

ESTABLISHING A MENTAL HYGIENE DEPARTMENT

Finally, there is the problem of the fifty-two hospitals that have neither their own neuro-psychiatric service, nor the attendance of a State or county clinic. It would seem unwise for such a hospital to select an untrained physician from its own staff to operate a mental hygiene clinic, since such a department needs a trained supervisor. Two other possibilities may be exploited, however. One is to invite a privately practicing psychiatrist to operate a clinic and to attend staff meetings. For instance, a certain city may have, say, three private practicing psychiatrists and seven hospitals, only three of them with mental hygiene clinics. These three psychiatrists may be invited to distribute themselves among the other hospitals, too, so that they may have this essential service. Or, if there is no psychiatrist in that town, one from a nearby city may be invited to open a one-afternoon-a-week or one-morning-a-week clinic. If there is no psychiat-

rist in Perth Amboy, there is one in neighboring New Brunswick. If there is no one practicing this specialty in Camden, there are many across the bridge in Philadelphia. If every hospital administrator would realize that his institution is incomplete without mental hygiene service, the deficiency could be swiftly corrected.

ISOLATED HOSPITALS

How about those hospitals located far inland with no psychiatrist near enough to make even a weekly visit? It seems to be worth placing before the medical profession of such a community the question of inviting a young psychiatrist, fresh from training, into such virgin territory. Offered hospital connections in an area devoid of psychiatric specialists, he will think the community worth a trial. The mere existence of such a practitioner in a new community is often enough to waken the doctors and hospitals to his need and his value.

OUT-PATIENT SERVICE FOR NEUROTICS

A word about the physical facilities. Certainly every hospital should have an out-patient service for neurotics, for problem children, and for the emotionally disturbed generally. No special equipment is needed; and the least that any institution can do is provide the space and encourage the personnel.

IN-PATIENTS' SERVICE

As to in-patients, the problem is a two-fold one.

First, a realization of the value of a psychiatric consultation on the emotional aspects of physical disease in in-patients.

Second, a consideration of actually constructing a unit for the short-term hospitalization of mentally disturbed persons.

The first problem—the use of psychiatric services for the emotional problems in general in-patients—needs only the awakening of the administrators and staff to the enriching influence of such a service. The equipping of a ward or wing for the reception of mentally disturbed patients would be the final step in making the hospital a well-rounded community health agency. The setting aside of such facilities is neither as expensive nor as

formidable as it sounds. I refer you to Dr. Frankel's Publication No. 18 of the Department of Institutions and Agencies for a workable little manual on this point. He tells you just how to do it. I think all general hospitals are going to come to it eventually, though the more alert administrators will get there sooner.

SUMMARY

To sum up: No hospital is complete that ignores the mental hygiene aspects of physical disease. No hospital is rendering an adequate community service that has no provision for

mentally disturbed persons. No hospital is doing a good educational job that robs its staff of the chance of learning something of the mental hygiene facets in physical disease. You can widen your institution's service, both to the doctors and to the public, by weaving the mental hygienist into the pattern of your hospital routine. It doesn't take much effort; it doesn't cost much money; it doesn't take any rebuilding. What it requires is an alertness to the need, and an honest willingness to meet it. The way is there. Shall we say that the will is lacking?

31 Lincoln Park

THE RESPONSIBILITY OF THE PHYSICIAN

By EDWARD W. SPRAGUE, M.D., F.A.C.S., Newark, N. J.

Presidential address of the Retiring President, presented before the Society of Surgeons of New Jersey, Newark, N. J., January 29, 1941.

Today we are witnessing a rapidly changing major upheaval in which the whole world seems adrift. The unkindly actions of fate, working by means of predatory traits of powerful organizations in totalitarian nations, have taken from many peoples their priceless liberties, and have destroyed their sanctuaries of peace. For many, all happiness has vanished, and even life itself is in constant jeopardy. We are no longer spectators in this serious tragedy. In this day of rapid communication and movement, we are easily caught up in the snarled web of events. Tremendous social consequences are upon us now, and will follow this war,—consequences which will not only affect nations as a whole, but likewise will injure the groups within nations, including the professions, the skills, and even the safety of the basic family unit. It is difficult to comprehend the seriousness or the limits of the problem facing us.

DUTIES AND RESPONSIBILITIES

Two fundamental age-old questions loom uppermost:

Shall personal values go down before the tyrants of force? The answer is—No.

Is Democracy, with its freedom of action in contradistinction to totalitarian regimentation,

capable of meeting the demands of mankind at this time? The answer is—Yes, if we are sufficiently intelligent and willing to help our generation find the way out.

It is the duty of the intelligent individual to be aware of the happenings about him; and it is the responsibility of representative men to hold fast to the abiding values of individualism. We realize that ruthless force in the crushing grasp of dictators is cruelly attempting to dominate the world and make free men slaves. We see all these inhuman acts of man crash down upon us, but waves of fear must not sweep us away from our belief in the ultimate power of reason. There is in the human mind a natural sense of truth, mercy, and justice which must eventually emerge and bring about calm and peace.

In the meantime, during this state of turmoil and insecurity the physician must realize that his training, his experience with people, his peculiar advantage from his understanding contacts with human weaknesses, place him in a position whereby he can render great aid in preserving the true ideals of our present age; and he can assure people that the end of the way of life which we cherish is far removed if we but hold steadfastly to the faith in that fundamental philosophy which guided our an-

cestors in the founding of this nation, and if we are willing to defend that belief with our might.

The true physician never lives wholly in the realm of his specialty, even though it seems to have a boundless horizon. Although he imposes severe standards upon himself, having a calm intelligence is not enough. He must never live in an ivory tower, so to speak. He must be about the world, and put his shoulder to the great task of inspiring courage and confidence in ourselves, and also to the task of dispelling fears bred in bewildering confusion. We must resist the base qualities of war—fear, hatred, prejudice, and greed, which are the four horsemen of the Devil—and stand or fall by what we believe to be best.

DANGER FROM SOCIALIZED MEDICINE

In these perilous times it is very natural for the herd to follow a leader, whether he be good or bad. We must be watchful, and recognize only good purposeful leadership. It is quite probable that, following the war, this country will experience a relapse into a most serious economic depression. Confusion of thought and misdirected action may follow. Even now, and more so then, plausible efforts may be made to develop schemes in an attempt to relieve certain unfortunate conditions in society. Various efforts or plans may be offered to the people which, while many may believe them to be sound and helpful, may be nevertheless extremely dangerous. Our profession must be especially watchful in our field of endeavor because one of such plans which is likely to be considered is some form of State or socialized medicine. It is the bounden duty of the profession to scrutinize thoroughly such action and oppose unsound plans, not on a selfish basis or routinely because political groups propose them, but on the real grounds that any form of State or socialized medicine is dangerous inasmuch as the patient may not receive the best form of medical care under such plans. We believe the best form of medical care is that under which the patient receives the greatest benefit; and in order to achieve that standard of care, it must be based on competitive practice and the free choice of physician by the

patient, and of the patient by the physician. Government must not take away man's inherent rights in his medical relationships. We must combat the modern theory of politicians that government alone should control our personal liberties.

No one is more interested in the high quality of medical care than the physician, and he must fight to maintain such a quality. Now, on the other hand, the physician is approvingly aware that helpful changes are taking place in the so-called practice of medicine, or *distribution* of medical services. Scientific attainments will continue to advance stupendously in the years to come. Medical costs may become somewhat higher. A smouldering, broader understanding by the public of the needs in medical care is gradually emerging; and the physician most of all, wishes medicine to fulfill its high destiny as an aid in the lives of men who are living out the purpose of this existence.

The so-called *new* social objectives of the day are not new to the medical profession. For centuries the physician has carried along the great burden of the under-privileged sick. The profession can, and should be, trusted as to leadership in this field; and we will surely meet the challenge of change. We are now developing help to the *low income group* through prepayment Medical Service Plans, and we should also persist in making the State assume its share jointly with us in the burden of caring for *the indigent*.

STANDARDS

It is the specific duty of an organization, such as the Society of Surgeons of New Jersey, to carry on and preserve the highest standards of the practice of surgery in this State. To do so we should be men articulate in our discrimination of good and of poor surgery. The science of surgery has traveled a long distance on the paths of discovery and achievement. The applied practice of surgery has likewise perfected itself in every line. A review of the yearly programs of this Society is veritable proof of that. This Society should continue to encourage apprenticeship, to demand thorough preparation, and to give opportunities for practical training. We should create

and stimulate the atmosphere of science and interest in our work, and assist every serious-minded, honest, hardworking man in his profession. Comparison of our own results with those of large established clinics should be done; from which conscientious self-judgment and appraisal will be most helpful. High percentages of autopsies must be obtained so that causes of failure may be courageously known.

Membership in this Society has always been an honor to be desired. It is our duty to continue that reputation by maintaining the high purpose, and increasing the influence of the Society. As a Society, we should labor everlastingly to maintain the existence of the American code of values of the spirit which are

fundamental; and we should continue to assume our full responsibilities and make the necessary determination to sacrifice voluntarily to the limit. Integrity, vision, and strong leadership are the needs of the hour. We must avoid over-self-confidence, and especially the great sin of smug complacency. We must face realities. We know that the strong and virile must work and live so that they may carry those who, by reason of disease, deformity, or circumstance, are less fortunate. We know that we must respect the dignity of man so that we may live with our neighbor. We must clearly identify ourselves with the forces of Democracy in the life battle against totalitarianism. We love freedom. Let us determine to live free.

THE MANAGEMENT OF INFECTED TONSILS, TEETH, AND SINUSES IN ARTHRITIS

By JOHN W. GRAY, M.D., Newark, N. J.

Read before the Section on Medicine of the Annual Meeting of The Medical Society of New Jersey in Atlantic City, N. J., June 5, 1940.

There are two great groups of chronic arthritis—rheumatoid arthritis, and osteoarthritis. It is generally conceded that there is no relationship between focal infection and osteoarthritis; while in rheumatoid arthritis there are two schools of thought, one believing that infection causes the disease, the other that it has nothing to do with it. This etiologic controversy goes on among investigators; while clinicians agree, for the most part, that it is an infectious disease. They are impressed with its prevalence in cold, changeable climates, and with its frequent association with upper respiratory infection. They are occasionally impressed with a dramatic cure following the removal of infected tonsils or teeth, but more often they are disappointed in this respect. We should not expect too much from the removal of infected foci, nor from any other single form of treatment. Unless every handicap is taken into consideration, and every form of treatment that may be expected to improve the patient's resistance is employed, the results will not be satisfactory. Whether we consider the infected focus a source of systemic infection producing

secondary localization around the joints, or whether we consider it only a menace to the general health, does not matter so long as we handle it intelligently and treat the patient as well as the focus.

The focal infection theory, which has been overdone in arthritis and also in other diseases, has resulted in unnecessary operations. The wholesale removal of tonsils and teeth for arthritis has created a timely reaction which has, however, over-corrected the fault by suggestion that the whole theory of focal infection in its relation to this disease should be thrown overboard. A middle course should be adopted, based upon an understanding of the factors involved in the defenses of the body against bacterial invasion, as well as an understanding of the various factors entering into the arthritic complex. There is a time when the removal of infected foci may be beneficial, and a time when it may do harm. Interfering with a partially walled-off focus may readily cause bacteremia; and if at the same time the patient is in a depleted state, the result may be disastrous.

In the more acute foci, natural immunity may be increased in a manner similar to that produced by the injection of dead bacteria as a prophylaxis against certain diseases. In low grade foci, it is probable that the absorption of endotoxins produces a particular sensitization of the tissues that predisposes to a lowered resistance. The rationale of vaccine therapy is based upon these two principles.

Many known factors predispose to joint susceptibility. There is probably a familial and an individual predisposition; there is the possibility of an intrinsically poor blood supply playing a part; and there is trauma. Polyarthritides may be produced in rabbits by the intravenous injection of large doses of living streptococci, but no arthritis occurs with the injection of smaller doses unless a joint is traumatized. Then that joint alone may become affected. A similar monoarthritides has been observed in infected individuals who are exposed to joint injury.

If the internist finds the tonsils to be persistently inflamed and presumably a menace to the patient's health, they should be removed,—but not when the patient is in a depleted state, and not until he is in a condition to handle the strain of an operation and the temporarily increased absorption of bacteria and toxic substances. Most rheumatoid patients need a period of rest in bed and supportive treatment, and frequently transfusions, prior to operation. The use of a desensitizing vaccine prepared from tonsil punctures is also a rational preoperative procedure. Not infrequently there is a history of a serious spread of arthritis following tonsillectomy at a time when the patient was already physically depleted. Such unfavorable reaction may be eliminated or reduced to a minimum if suitable preoperative treatment is given.

The question of teeth is frequently a difficult one to answer. Although there is a general rule that teeth showing x-ray evidence of infection should be extracted, it is possible that traumatic shadows may be mistaken for abscesses, or that early apical infection may be overlooked. Devitalized teeth should be x-rayed at frequent intervals. Pyorrhea may be as serious

as apical infection, and ordinarily receives too little attention.

In my own experience, about ten years ago, a molar tooth showed an apical shadow which was diagnosed by one dentist as an abscess, by another as a traumatic condition. After correcting a faulty occlusion, the shadow cleared up and I still have the tooth. On the other hand, the experience of a confrere was quite different. Twelve years ago he developed a severe pain in the lumbar region. X-rays of the teeth were negative for focal infection, and no other foci could be found. Fourteen physicians including several prominent consultants were in attendance. There were x-ray changes in the third and fourth lumbar vertebrae suggestive of malignancy. He was confined to bed four months, a plaster cast was applied for twelve weeks, and morphine was required. Finally after the extraction of five devitalized teeth there was a most dramatic relief of symptoms. He was able to resume practice in one month and has been well since that time.

Chronic sinus infection is the most troublesome focus in rheumatoid arthritis, principally because of the frequency of arthritic recurrences following sinus attacks. One should never be casual about low grade sinusitis. Although the rhinologist may report the sinuses as "clear" because there is "no pus", or because the transillumination of the antra is negative, the internist should not disregard the significance of an inflamed granular pharynx. Local shrinkage treatment is frequently indicated, and operation occasionally needed for establishing good drainage. Supportive treatment is essential in all cases. The patient should have extra hours of rest, avoid fatigue and exposure, and be built up in every respect. Nevertheless, when all these measures are carried out, we are frequently confronted with the same discouraging recurrences from upper respiratory infection in rheumatoid arthritis as in rheumatic fever. I regret that all rheumatoid patients suffering from chronic sinusitis cannot afford to spend the Winter months in a warm, dry climate.

Other foci, such as infected cervix, prostate and gall-bladder are occasionally found, but do not concern us in this discussion.

An analysis for focal infection of the tonsils, teeth, and sinuses was made in 200 arthritic cases. One hundred of these were rheumatoid arthritis, and 100 osteoarthritis. See Table 1.

TABLE 1

AN ANALYSIS FOR FOCAL INFECTION OF THE TONSILS, TEETH AND SINUSES IN 200 ARTHRITIC CASES

	100 Rheumatoid Arthritis	100 Osteo- arthritis
<i>Tonsils</i>		
History of tonsillitis	55	21
Onset following attack	8	0
History tonsillectomy	51	28
Prompt improvement	4	0
Exacerbation	5	0
Tonsillitis after seen	35	14
Tonsillectomy after seen	13	3
Prompt improvement	3	0
Exacerbation	0	0
<i>Teeth</i>		
History of extractions	53	60
Prompt improvement	2	0
Exacerbation	3	0
Infected or non-vital after seen	20	14
Extractions after seen	12	6
Prompt improvement	2	0
Exacerbation	0	0
Pyorrhoëa	12	6
<i>Sinuses</i>		
History of sinusitis	45	14
Onset following attack	7	0
Inflammation after seen	46	18
Arthritic recurrences after at- tacks	24	0
<i>Laboratory Data</i>		
Sedimentation rate—increased ..	88	8
Average	37	7
Streptococcal agglutination—		
Positive	74	27
Average dilution	490	27
Blood cultures, streptococcus ...	14	0
Joint cultures, streptococcus ...	2	0

In the rheumatoid group, the tonsils, teeth, and sinuses were frequently infected; the onset not infrequently followed attacks of tonsillitis and sinusitis; arthritic exacerbation followed removal of infected tonsils and teeth when the patients were in a depleted state; such exacerbations did not occur when sufficient preoperative supportive treatment was given; arthritic recurrences frequently followed sinus attacks and "head colds", and the laboratory findings pointed toward infection in a high percentage of these cases.

In the osteoarthritic group, infection of the tonsils, teeth, and sinuses occurred less than half

as frequently; there was no history of a relationship of such infection to the onset; the joints were no better and no worse following removal of foci; sinus attacks never caused recurrences; and laboratory tests showed no evidence of infection.

Although the incidence of infection was high in rheumatoid arthritis, the number showing prompt, definite, sustained improvement following tonsillectomy or extraction was small. All cases showing marked improvement were in the earlier stages of the disease, there being no apparent direct effect in the advanced cases. There is no way, however, of evaluating indirect beneficial effects, nor do we know what effect the absorption of toxins may have on non-infectious metabolic or degenerative diseases. The most striking figures occurred in the tabulation of recurrences following sinus attacks.

Two case reports will illustrate the importance of conditioning rheumatoid arthritic patients for tonsillectomy.

CASE 1

M. G. W., female, aged 49. Duration when seen, one year. There was typical fusiform swelling of the proximal interphalangeal joints, and the ankles and knees were seriously involved. Although there was very little history of sore throat, the tonsils were purulent. The patient was anemic and underweight. The following treatment was given: Rest in bed, high caloric diet, hematronics including transfusions, and desensitizing streptococcal vaccine prepared from tonsil puncture. Tonsillectomy was done after six weeks. There was no exacerbation. She returned to work six months after seen. One year later all symptoms and signs of the disease had disappeared, and there have been no recurrences during eight years of subsequent observation.

CASE 2

E. P., female, aged 30. Duration when seen, two years. During the first year only the finger joints were mildly involved, but there was a great loss in weight and strength during that time. The tonsils were removed at the end of the first year, and then all of the joints became so seriously involved that when seen at the end of the second year the patient was unable to walk. After one year of intensive supportive and corrective treatment the activity of the disease was checked, but irreparable damage with ankylosis and deformity had taken place in many joints. This case shows the danger of operating at a time when the patient is in a depleted state.

It is difficult to evaluate the effect of removal

of infected foci upon the course of rheumatoid arthritis because such procedure is only one of the many forms of treatment used in a comprehensive plan. Furthermore, it is impossible to draw conclusions regarding any form of

treatment of a chronic disease in which spontaneous remissions occur, except by the observation of a large group of cases.

Summary of the results of all forms of treatment in 100 cases of rheumatoid arthritis:

No. Cases	Duration When Seen	Not Improved	Improved	Greatly Improved	Arrested
33	1 mo.-1 yr.	2	9	10	12
23	1-2 yrs.	3	5	3	12
25	2-5 yrs.	3	8	7	7
19	5-22 yrs.	2	9	4	4
—	—	—	—	—	—
100		10	31	24	35

CRITERIA FOR ARRESTED CASES

Joint signs absent, or inactive residual.

Symptomatically cured. Normal sedimentation.

Absence of recurrence one or more years (above cases observed in arrested state, 1-10 years).

CONCLUSIONS

1. Infected tonsils, teeth, and sinuses are frequently associated with rheumatoid arthritis.

2. Such infections appear to have a relationship to the onset and course of this disease.

3. The internist should decide if, and when, tonsils and teeth are to be removed.

4. The removal of foci alone seldom yields satisfactory results.

5. Operative procedures may be definitely harmful in depleted patients.

TRAUMA ASSOCIATED WITH MALIGNANCY

By LOUIS J. LEVINSON, M.D., and NATHAN J. FURST, M.D., Newark, N. J.

From the Department of Roentgenology and Radiation Therapy, Newark Beth Israel Hospital. Read before the Section on Radiology of The Medical Society of New Jersey, at Atlantic City, on June 5, 1940.

The relationship between trauma and malignancy is discussed in this paper chiefly in respect to Workmen's Compensation cases. In these cases a specific evaluation must be made as to the responsibility of the trauma in the etiology and progress of a malignant neoplasm.

These patients can be divided into two distinct groups:

The first group consists of those individuals in which the trauma seems to have a definite bearing on the *development* of the neoplasm.

The second group,—usually the more common,—consists of those patients in which the trauma either aggravated or revealed a *pre-existing* malignancy.

CRITERIA OF MALIGNANCY FROM TRAUMA

Dr. Ewing in 1926, in a review of the subject of "Traumatic Cancer", suggested certain

criteria before accepting *trauma* as an etiologic factor in malignancy. These criteria are as follows:

1. The authenticity and sufficient severity of the trauma.

2. Previous integrity of the wounded part.

3. The identity of the injured area with that giving origin to the tumor.

4. The tumor must be of a type that could conceivably result from trauma.

5. There must be a proper time interval between the receipt of the injury and the appearance of the tumor.

Such data are often difficult to obtain; and without these facts, one cannot assert that a neoplasm is of traumatic origin.

In the first group we are presenting two interesting cases which seem to meet most of the above criteria.

CASE 1

H. W., white, male, aged 22.

Occupation: Laborer and mechanic.

Family History: Mother died of cancer of cervix.

Patient was injured on November 5th, 1938. While loading a truck a 100-pound can of white lead slipped and struck the inner part of the left thigh. His thigh was bruised, but he continued to work that day. The following day he noted soreness and slight swelling, but no definite ecchymosis. He visited his physician the day following the accident and was given baking treatment over a period of two weeks. At this time, two weeks after injury, he first noted a definite increase in swelling over the injured area. One month after injury, a Roentgen examination was made. The roentgenologist, who reported the finding in this case, diagnosed a possible ossifying hematoma, following injury.

Local treatments were continued and the swelling became progressively worse. He was admitted to the Newark Beth Israel Hospital August 28, 1939, when Dr. Furst and I first saw this patient.

On admission, a large mass, almost the size of a football, was noted on the medial side of the middle third of the thigh. The mass was explored surgically by Dr. Max Singer, and sections were taken for biopsy.

The mass was found to be somewhat cystic, and contained fresh and old blood inside a lobulated cavity. There was also soft cauliflower-like tissue. Roentgen examinations were made of the chest and local tumor.

Dr. Furst's report on the Roentgen examination was as follows:

"Examination of the thorax shows numerous metastatic nodules invading both the left and right lung field, the greatest intensity on the left side. Exposure of the left thigh shows a fairly large malignant neoplastic invasion of the mesial posterior aspect of the intermediate third of thigh. The infiltration seems to be entirely within the soft structures. No definite osseous connection is demonstrable.

"Diagnosis: Fibro-fascial sarcoma."

The microscopic diagnosis on the biopsy was reported by Dr. Antopol as "Synovial sarcoma".

Because of the chest involvement, only palliative therapy was considered in this case. This consisted of Roentgen therapy to the anterior and posterior thigh. Between 300 and 400 "r" units were given daily to one field at a time. The anterior field received 4000 "r" units, and the posterior field 2700 "r" units in air, voltage 200 K. V. and filtration $\frac{1}{2}$ mm. copper and 1 AL, dist. 50 cm. Treatment was instituted on September 12, 1939, and completed November 15, 1939. Following this treatment the lesion commenced to shrink in size, and exposures of the thigh on April 18, 1940, showed a marked decrease in the size of the previously reported neoplastic invasion of the soft structure.

At present he is receiving palliative x-ray therapy to the lung metastases with no definite response. Clinically, patient feels improved.

CASE 2

W. Z., white, male, aged 49.

Occupation: Structural ironworker.

Family History: Mother died of cancer of breast.

Patient was injured on June 17, 1937, when iron beams fell and struck him on left breast. The nipple was ripped off, and he also had bleeding from the nose and mouth as a result of the accident. In his past history the patient stated that previous to the accident he had a lump in his left breast for about five years. This lump was firm and about the size of a bean. Following the accident an ulcer resulted in the left breast, which was treated for four months with wet dressings and salves, without any response.

He was admitted to the Newark Beth Israel Hospital on November 11, 1937. Examination at this time showed the left nipple entirely sloughed off, resulting in an oval ulcerated area about two cm. in diameter, one cm. deep. There was marked induration in the left axilla involving the skin fat and muscles of the pectoral region. His temperature was septic and reached a peak of 104° F. A tentative diagnosis of cellulitis of the left axilla, with deep abscess and possible malignancy, was made.

On November 17, 1937, Dr. Danzis incised an abscess cavity which extended up to the apex of the axilla, underneath the insertion of the pectoralis muscle. Part of the ulcer was excised for microscopic examination.

Microscopic diagnosis was: Infiltrating adenocarcinoma, with anaplastic areas of inflammation and necrosis.

Subsequent treatment consisted of a combination of interstitial radium and x-ray therapy administered by Dr. Friedman and myself. Patient is still living three years following the accident, although he has evidence of recurrence, and is under treatment now.

In reviewing cases one and two, we find two individuals with a definite family history of cancer. In the first patient, we have what appeared to be ossifying hematoma, later proven to be a synovial sarcoma. This case as yet has not appeared before the Compensation Bureau for a definite decision.

In the second patient, the sequence of the relationship between the injury and the development of the cancer is complicated by the previous history of a preëxisting tumor in the breast, of five years' duration, which probably was a benign fibro-adenoma.

In a recent report from the Mayo Clinic, "Miller and Harrington" reported a series of fibro-adenomata undergoing malignant changes. These were clinically, as a rule, of low-grade

malignancy. Out of fourteen cases reported, they noted a definite history of trauma in only one case.

Our second patient received a favorable verdict from the Compensation Bureau. This was based on the assumption of aggravation, by the injury, of a previously existing tumor.

From the second group of cancer cases following traumatism we have chosen two patients who demonstrate the subsequent discovery of malignancy following injury while at work. In these patients the tumor, though present, was probably asymptomatic until the injury occurred.

CASE 3

C. R., white, male, aged 38.
Occupation: Laborer.

Admitted to the Newark Beth Israel Hospital on November 6th, 1939, with a history that, approximately five months before admission, the patient struck the vertex of his skull with a pipe while he was at work. There was no loss of consciousness, but slight dizziness was present for two hours. He then forgot about the accident.

Two months before admission he began to suffer from headaches and dizziness, with occasional vomiting. Recently he had found that he could not use his left upper extremity as well as he used to.

On examination the left grip was found to be slightly weak. The left knee jerk and ankle jerk was slightly more active than the right. There was a suggestive Babinski, and a definite Gordon on the left. His tongue deviated slightly to the left. Spinal fluid showed a pressure of 260 mm.'s.

On November 8, 1939, encephalography was performed and showed the presence of a right cerebral expanding lesion. Subdural hematoma was suspected, and therefore on November 9, 1939, a right trephination was performed by Dr. William Ehrlich. This showed no evidence of a subdural hematoma. A large fronto-temporo-parietal osteo-plastic flap was turned down, and in the central area, high up near the falx, a deep glioma was found.

Surgical intervention was limited to a generous biopsy. Grossly, the tumor appeared like an infiltrating inoperable glioma, and since it was in the motor area, no attempt at extensive removal was made.

The patient stood the procedure well until five days post-operatively, when he developed a pulmonary complication, became progressively worse, and expired on November 17, 1939.

The tumor proved to be a glioblastoma multiforme. Gross and Ehrlich in their recent book, "Diagnosis and Treatment of Head Injuries", state:

"The rôle of trauma in the causation of tumors of the brain has occasioned considerable controversy. This problem is of great medico-legal importance. Cushing's opinion was as follows: The

relation between trauma and the first appearance of symptoms is a coincidence that occurs too often to be ignored. Though trauma may not actually cause, it may serve to bring a preëxisting lesion into prominence."

The Insurance Company accepted responsibility for the medical expenses in this case on the supposition that the lesion was a post-traumatic hematoma. However, when the tumor was discovered, they decided to contest their responsibility; and a final verdict has not as yet been rendered.

CASE 4

D. O., white, male, aged 36.

Occupation: Structural steelworker.

Admitted September 8th, 1939, to Newark Beth Israel Hospital with a complaint of constant excruciating pain traveling down his left thigh and leg. Patient was bedridden. Two months prior to admission, in July, 1939, while walking along a steel beam, he fell, landing on his left buttock and thigh. He was able to limp away and received first aid. This was followed by baking treatments for about seven weeks thereafter. However, pain persisted and became progressively worse.

On admission to the hospital, with exception of marked muscle spasm in the affected left extremity, the physical findings were not significant. Laboratory findings were also negative.

Roentgen examination by Dr. Furst showed a considerable alteration in the structure of the cancellous tissue surrounding the acetabular cavity. There were alternating areas of rarefaction and fibrosis. The proximal end of left femur was also invaded.

A needle puncture for biopsy was not successful.

A tentative clinical diagnosis of a myeloma was made.

This seemed to be borne out by response to x-ray therapy. Following a series of daily treatments totalling 3600 "r" units to the left anterior pelvic portal and 3600 "r" to the left posterior pelvic portal, there was marked improvement in the clinical symptoms. The patient was able to walk, and was discharged November 11, 1939. Two weeks later he was readmitted to the hospital, with intractable pain in the lower back, radiating down both extremities.

Radiographic exposures at this time showed further progress of the destructive lesion in the femur and the hip joint.

X-ray therapy gave no definite relief at this time, and it was discontinued. On January 27, 1940, six months following the injury, patient expired.

An autopsy performed by the County Medical Examiner revealed metastatic involvement of the kidneys, liver and adrenals. Microscopic examination showed an anaplastic carcinoma. The specific origin has not been determined.

It is interesting to note that in this case we

have a man who was able to work until his injury. A fulminating malignancy was discov-

ered following this injury, which caused death within six months.

CONCLUSION

1. In order to determine the relationship between injury and malignancy, accurate and detailed histories are of extreme importance.

2. In some patients a specific relationship seems to exist between the injury and the sub-

sequent development of a malignant tumor.

3. Early roentgenograms are of great importance in patients with persistent complaints following even trivial injuries, in order to rule out preëxisting neoplasms.

RESPIRATORY ALLERGY

PRACTICAL POINTS IN DIAGNOSIS AND TREATMENT

By J. ALEXANDER CLARKE, JR., M.D., Philadelphia, Pa.

Outline of an address to the Gloucester County Medical Society on February 20, 1941, in Woodbury, N. J.

Allergy may be defined as an unusual reaction, on second or subsequent exposure, to substances that are usually harmless. Based on the pathologic lesion produced, allergy may be divided into four subdivisions.

First, Edematous.—Here the lesion is a simple edema, and may occur in any mucous membrane of the body, or in the skin as urticaria. The respiratory tract is most frequently involved. The effects of allergic edema are well known as asthma, hay fever, and allergic catarrh or vasomotor rhinitis. Next in frequency is the gastro-intestinal tract. Probably because it is inaccessible to foreign substances, the genito-urinary tract is rarely if ever the seat of an edematous allergy.

Second, Inflammatory.—The lesion here is a simple inflammation, and at present is recognized almost exclusively in the skin as contact dermatitis and eczema. Poison ivy dermatitis, which comes under this heading, is the most common of all allergies. Vernal catarrh is a rare manifestation. Tuberculin sensitivity is an allergic inflammation.

Third, Spasmodic.—The lesion in this type is a spasm of smooth muscle as seen in anaphylaxis in certain of the lower animals. The term anaphylaxis should be restrict to this form, and not used as a synonym for allergy. Anaphylaxis has not been described in human beings.

Fourth, Hemorrhagic.—This little-investigated form of allergy has only recently been

recognized in purpura resulting from second contact with the drug "sedormid".

RESPIRATORY ALLERGY

Respiratory allergy is most important to clinicians, because much real progress has been made in its treatment. It may be divided into nasal and bronchial.

Nasal allergy can be further subdivided into seasonal (hay fever), and non-seasonal (allergic catarrh or vasomotor rhinitis).

The chief causes of failure in the treatment of hay fever are:

1. Overdosage, particularly during the season when the concentration of pollen in the air is very high.

2. Abnormalities existing in the nose prior to the season, such as sinus infection, polyps, or deflected septa (good results cannot be expected in an abnormal nose).

3. "Synergy", or a reaction to substances other than pollen,—feathers for example. These side reactions may cause little or no trouble except during the pollen season. They should be appropriately treated in addition to the usual pollen injections.

NASAL ALLERGY

Non-seasonal nasal allergy, or allergic catarrh, is of importance because of its effect on the general health. A poorly-functioning nose increases the energy expended in respiration, and interferes with rest and sleep. The symp-

toms may be so mild that the condition is entirely overlooked by both physician and patients. Nasal allergy may be the underlying cause of gastric neurosis in adults, or behavior problems in childhood. Persons can suffer as severely from nose strain as from eye strain.

BRONCHIAL ALLERGY

Bronchial allergy may be divided into three stages:

1. A preasthmatic stage;
2. A stage of intermittent asthma; and
3. Continuous asthma, characterized by hypertrophy and infection of the bronchial mucosa.

The acute attacks of dyspnoea, characteristic of asthma, are preceded by a period of a few months or years during which the sufferer has comparatively mild bronchial symptoms, such as cough, wheezing, or slight dyspnoea on exertion. It is in this stage that the diagnosis of bronchial allergy should be made and vigorous treatment instituted. If this is done, the more distressing second and third stages may be avoided in many persons.

The second stage of bronchial allergy is characterized by intermittent attacks of asthma

with intervals of complete freedom. This is usually caused by contact with external substances (allergens). Appropriate treatment, either elimination or hyposensitization (injections), is usually possible, and the results obtained are the most gratifying part of an allergy practice.

In the third stage, in addition to the acute attacks of edema, there is a true *hypertrophy* of the mucosa. There is a great increase in the number of glands and the membranes are thrown into folds. This greatly interferes with the expulsion of mucus, which stagnates and causes infection of the membrane itself. The treatment of this stage is most difficult and disappointing. Furthermore, it is frequently complicated by other changes within the thorax, which interfere with bronchial motion. These include old scars of tuberculosis, pleural adhesions from former pneumonias, cardiac hypertrophy, etc.

The treatment of the third stage is the same as treatment of the first and second, plus rest. Prolonged bed rest and forced feeding is still the best treatment for chronic infection anywhere in the body. It will give these unfortunate sufferers more relief than any ambulatory treatment.

334 South 21st Street

FUNCTIONAL DISTURBANCES OF THE GASTRO-INTESTINAL TRACT

By EDWARD WEISS, M.D., Philadelphia, Pa.

From the Department of Medicine, Temple University School of Medicine, Philadelphia, Pa. Presented before the Combined Section on Medicine and Gastro-enterology at the Annual Meeting of The Medical Society of New Jersey, in Atlantic City, June 4, 1940.

Between the small number of obviously psychotic people whom a physician sees and the larger number of patients who are sick solely because of organic disease are a vast number of sick people who are not "out of their minds" and yet who do not have any definite bodily disease to account for their illness.

It is reliably estimated that about one-third of the patients who consult the physician fall into this group. These are the so-called purely *functional* problems of medical practice. Approximately another third of the patients who consult a physician seem to have symptoms that are in part dependent upon emotional fac-

tors even though organic findings are present. To dispose of the first question—Should the general physician treat illness of emotional origin?—the answer is that he must. The problems are so numerous in his practice and the interrelationships of emotions and bodily functions are so intimate and often so indissoluble, that he cannot avoid them.

What is the matter with these patients and how should they be treated? They are suffering from disturbances in their emotional lives; that is, the illness is of psychological origin and can be satisfactorily studied and treated only from a psychological standpoint. The ill health

arises from long-standing dissatisfactions in the business, social or home life of the individual and this failure of adjustment to environment is manifested by a disturbance in some part of the personality, either as bodily symptoms of various kinds, capable of mimicking almost any disease, or as affections of the spirit resulting in attacks of anxiety, obsessions, phobias, depression and other disturbances of mood. Chief among the symptoms which arise from such a failure of adjustment to environment are gastro-intestinal disorders, because the abdomen can truly be said to be the sounding board of the emotions. More will be said on this point shortly.

Can any advice be given as to how to deal with such patients? In a general way it consists, in addition to the physical study, simply in getting to know the patient as a *human being* rather than only as a medical case. Too often the patient is looked upon as a physiological mechanism and is studied by means of medical history and physical examination, aided by instruments of precision and chemical tests. Tape measures and test tubes carry the erroneous notion of exactness and thoroughness—erroneous because the emotional life of the individual which may hold the key to the solution of the problem is not investigated or at best inadequately so.

Probably the best way to deal with these patients is first to satisfy ourselves and establish their confidence by a thorough medical history which must contain more information regarding the family and social background of the patient than our present histories do; then a complete physical examination and such laboratory tests as are necessary to exclude organic disease or to establish the precise nature of the organic problem and the amount of disability which it in itself is capable of causing.

Then a method of helping patients to understand their symptoms which I find useful is based upon the symbolism of symptoms. I often say to them that if they cannot find an outlet for tension of emotional origin by a word or action, the body will find a means of expressing this tension through a kind of "organ language". For example, if a patient

cannot swallow satisfactorily and no organic cause can be found, it may mean there is something in the life situation of the patient that he "cannot swallow". Nausea in the absence of organic disease sometimes means that the patient "cannot stomach" this or that environmental factor.

This whole approach can be summed up in the following fashion; if symptoms exist without an organic basis or, if organic disease fails to explain the symptoms completely, look for their meaning from the standpoint of behavior.

To answer one of the question raised by physicians regarding these matters, "Suppose you do find something of importance in the emotional life of a patient, some conflict that is causing illness, what can you do about it? What good does it do the patient to know?" First of all, it is often a great help to the patient to know that the ailment is not organic in origin, but is due to a disturbance in his emotional life. When a neurotic symptom is divorced from a fear of organic disease, cancer for example, it loses its force and then the slogan, "carry on in spite of symptoms" often helps the patient a great deal. This is especially true if the emotional background of the illness is made clear to the patient.

Simple reassurance, unless combined with an analysis of the illness from the standpoint of the behavior, gives these patients only temporary help, and depending upon the degree of anxiety has to be constantly repeated, like a dose of digitalis in a failing heart. Closely allied to reassurance is another superficial treatment that rarely results in more than temporary help—environmental manipulation without any attempt to give the patient insight into his conflicts. Real psychotherapy, which is directly the opposite of simple reassurance, tries to make the patient understand the meaning of his symptoms and the nature of his conflicts. It is a reëducational process so that the necessity for symptom formation is abolished. It is my contention that every physician should be trained in psychological medicine so that he may be able to understand and manage the many emotional problems that are presented to him daily.

It should be noted, however, that there is a major and a minor psychotherapy; and while the general physician should be able to treat the minor ailments, he must be able also to recognize when the problem is beyond him and then refer the patient elsewhere for major psychotherapy. Such knowledge and such an approach will frequently save the patient unnecessary, troublesome, and expensive medical or surgical

treatment with a resulting further degree of invalidism.

Medicine had its real beginning in the study of a man at the dissecting table. Let us continue with the study of man not only as a physiological mechanism but as a human being possessed of loves and hates, urges and passions capable of disturbing his soul and his body.

269 South 19th Street

HEMORRHAGE LATE IN PREGNANCY AND LABOR

MATERNAL WELFARE ARTICLE NUMBER FIFTY-EIGHT

By JAMES FRANCIS NORTON, M.D., F.A.C.S., Attending Obstetrician, and
JOSEPH P. DONNELLY, M.D., Assistant Attending Obstetrician,
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We wish here to emphasize the importance, the frequently tragic character, and the almost always emergency nature of bleeding from the birth canal late in pregnancy and labor. We are not now dealing with hemorrhage seen *early* in pregnancy—e. g., that due to abortion, mole, or ectopic pregnancy; nor will we concern ourselves with the bloody vaginal discharge which accompanies erosion of the cervix, nor that due to neoplasms and the like causes, when they complicate pregnancy.

The bleeding under consideration here is that which accompanies the major emergencies of clinical obstetrics, and which requires for its adequate management an almost rigorous adherence to some very fundamental principles which, in our hands, have proved of real value and merit in the clinical management of these problems, and have contributed much toward affecting a low maternal mortality rate.

This type of bleeding falls quite naturally into the four clinical divisions of:

1. Abruptio of the placenta;
2. Placenta previa;
3. Rupture of the uterus, and
4. Postpartum hemorrhage.

The source of all this bleeding (excepting that seen in rupture of the uterus and in laceration of the birth canal) is the *placental site*. Certainly, it can be said that before the expulsion of the child, uterine hemorrhage is asso-

ciated with the separation of a placenta that may be situated either normally or abnormally in the uterus. The placenta may attach itself to any part of the uterus, but the fundal type of attachment is considered the rarest of all; and the most frequent is that in the body of the uterus. The normally situated placenta, is, of course, one located in the body of the uterus; while the abnormally situated placenta is one which lies either over the internal os, or within ten centimeters of the internal os.

1. ABRUPTION OF THE PLACENTA

The normally situated placenta, as a general thing, remains firmly adherent to its underlying uterine attachment until after the completion of the second stage of labor. However, for a variety of reasons,—toxemia, chronic nephritis, disease of the endometrium and ovum, perhaps trauma,—there occurs a separation of the placenta which is normally situated, sometimes late in pregnancy or labor; and when this occurs, one is dealing with an *abruption of the placenta*, or an accidental hemorrhage. This is not an infrequent occurrence. In the five years—1935 through 1939—at the Margaret Hague Maternity Hospital, there were 281 cases of abruption of the placenta in 27,000 consecutive deliveries.

Ordinarily many of these cases are regarded as cases of placenta previa, because placenta

previa seems to be better understood, and there is a tendency, in some quarters at least, to regard all bleeding from the birth canal in the last trimester of pregnancy as due to placenta previa. This attitude may well spell disaster as we will presently show, because, while many cases of placenta previa of the incomplete type may go on through labor quite easily and with no interference, nevertheless, on the other hand, some of the complete or tragic types of abruption require some very active and judiciously selected type of interference.

Now, pathologically, what happens to cause the normally situated placenta to become separated before the onset of labor or before the completion of the second stage of labor? The initiating factor is, as yet, not too well understood, but many of these cases do have a *toxemic* element present. The sequence of events, once the process is set in motion, is well marked out and as well understood. There is a hemorrhage into the decidua basalis bringing about a retroplacental hematoma with a greater or lesser separation of the placenta from its underlying uterine attachment. There is produced, really and pathologically, an abortion at or near term.

The small separations are not important clinically; and not infrequently they are evidenced by no external bleeding, and are accompanied by no unusual or untoward clinical course. The diagnosis of the lesser degrees of separation is made only on careful inspection of the expelled placenta. There on the maternal side, one finds a blood clot of some consistency and varying size which causes a definite depression in the placental substance.

If the hemorrhage into the decidua continues, however, and there is an extensive or complete separation of the placenta, then one is face to face with one of the most formidable major catastrophes in obstetrics.

The clinical picture is that of a woman in the last trimester of pregnancy, perhaps toxic, in severe shock. If seen early, there may *not* yet be an appreciable amount of external bleeding. But after the picture develops, and after there has been considerable internal hemorrhage, we have then the full-blown story of shock, plus hemorrhage. The patient is cold, sweating, and complaining of persistent and

unrelenting abdominal pain. The blood pressure has fallen, the hemoglobin is down, the pulse is small and rapid. The abdomen usually is very hard, tender, and extremely painful. The fetal heart, quite likely, will be lost (depending upon the amount of placental separation). The uterus does not relax, and there are no rhythmic uterine contractions. Because of the tenseness and tenderness of the uterus, it is impossible to map out the fetal parts.

On rectal examination the cervix is usually found to be but little dilated, and but little effaced.

The indications governing the active management of the cases are twofold:

1. To combat shock, and
2. To arrest the hemorrhage.

TREATMENT FOR SHOCK

The patient's general condition should be attended to immediately, and *before any attempt is made to undertake any method of delivery*. A sedative should be administered, and external heat provided. Provision must be made for the administration of fluids intravenously (10 per cent glucose in saline)1000-1500 c.c.; and preparations made for the transfer of the patient to a hospital for the arresting of the hemorrhage and the completion of her delivery.

No hurried nor forceful attempts at delivery should be made, for the patient generally is in wretched condition and nothing should be attempted without first improving her general condition. This is so important that it is hardly possible to over-emphasize it. In the interim between the beginning of the glucose-saline intravenously and the beginning of any operative procedures, a suitable donor should be procured, the operating room set up, and some blood should have been given.

Transfusion in the management of these and all other bleeding cases in obstetrics is of transcendent importance. So strongly do we feel about it that if, after an attempt to obtain volunteer donors, we are still without a suitable donor, the administrative authorities of our hospital, out of its own funds supplies a professional donor. Positively, we are convinced that our figures are in no small measure traceable to the repeated use of transfusion in these cases.

CONTROL OF HEMORRHAGE

We are now ready to meet the second of the two indications—the control of the hemorrhage, or the active management, or the emptying of the uterus.

The method selected to empty the uterus will vary with the period of the pregnancy, the patient's general condition, and the character of the cervix with which one is confronted.

In the severe, tragic types of abruption with prominent symptoms of shock and hemorrhage, temporizing will not suffice. The woman is in grave danger, and only prompt and intelligent treatment will save her, and at times even that may fail.

The indication is to empty the uterus without adding any unnecessary shock. But how is one to do this? The answer lies in the *condition of the cervix*; this makes the difference between success and failure.

There are several methods offered:

1. Rupture the membranes, and then either permit the labor to go with the expectation of a normal spontaneous delivery; or, when the situation permits, to terminate the labor with a forceps operation.

2. If the cervix is sufficiently dilated, a version has been suggested. This may well be very dangerous because one may oftentimes be mistaken when it comes to an evaluation of the exact condition or potentialities of the cervix.

3. Plugging the vagina with pledgets of cotton balls or some similar substance, putting on a very tight abdominal binder, and another rather tight "T" binder—after the Rotunde method of treatment. We have no experience with this method, and we are unable to pass any opinion upon its merits.

It is safe to say that there exists no justifiable hope for any type of vaginal delivery unless there is an appreciable degree of cervical dilatation. In all the severe forms of abruption, it has proved far safer for us to do a Caesarean section. In this manner, not only do you surely and directly control the bleeding, but you can visibly assure yourself of the retraction, contraction, and tone of the uterus, after the removal of the baby. You can prove or disprove the presence of a Couverlaire type of uterus which is associated with the severer forms of abruption. The so-called uteroplacental

apoplexy, with blood extravasated out into the substance of the uterus, causes a dissociation of the individual muscle fibers, and so renders it impossible for the uterus to retract, and therefore predisposes to a subsequent fatal postpartum hemorrhage.

In the severe cases where the unprepared cervix offers an obstacle to delivery through the birth canal, we in our clinic, having first transfused the patient, and having cared for her general condition, terminate the pregnancy by Caesarean section. The uterus is watched, after an oxytocic has been administered, for its power of retraction and contraction. If it is determined that the uterus will remain contracted, nothing more is done—the uterus is left. If it does not contract, or having once contracted it again relaxes and begins to bleed, a hysterectomy is carried out. All this time the patient is being given blood by indirect method.

So many of these cases have a toxemia of pregnancy that one should not consider the problem entirely solved with the successful completion of the operation,—for, besides the danger of atony of the uterus already stressed, there still remains the danger of the toxemia of pregnancy. We have seen some of these cases go on to a postpartum eclampsia.

Since 1935 we have had 281 cases of abruption with nine cases of uteroplacental apoplexy. There was one death in the entire group.

2. PLACENTA PREVIA

The second of these very important and sometimes fatal bleeding entities of late pregnancy or early labor is *placenta previa*.

What accounts for the position of the placenta in the lower uterine segment is still controversial. It seems to be more prevalent in multipara, and in patients who have had some kind of interference in their decidual development, e. g., previous endometritis, manual removal of the placenta, infected abortion, or similar conditions.

The diagnosis is relatively easy—painless bleeding occurring in what is an otherwise normal pregnancy.

We would like here, to make an especial plea for the immediate recognition of the inherent serious potentialities of this type of bleeding. The first bleeding may be of an inconsequential

nature; it may not be of an alarming degree; the patient herself may ascribe no great importance to it; the bleeding episode may pass off and not recur immediately. You may very easily be lulled into a sense of false security.

The very serious potentialities of any bleeding late in pregnancy must ever be borne in mind if we are to effect any material reduction in the maternal mortality associated with the bleeding states. All such bleeding must be interpreted as a red flag—a danger signal—and not to be passed by without the very greatest caution. The pregnancy under consideration can no longer be considered normal until one definitely determines the cause of the bleeding to be not serious. So great is the importance which we ascribe to these cases at our hospital that we admit, immediately and routinely, to the antepartum floor, every case which has any bleeding during pregnancy, for an immediate and accurate evaluation of its source.

The diagnosis of placenta previa is relatively easy—the painless bleeding, the feeling of a placenta either encroaching upon or covering the internal os, and now, x-ray findings of the placenta in the region of the cervix.

The most important problem from the standpoint of management is the determination of the condition of the cervix and the type of placenta previa. Upon the accurate evaluation of the condition of the cervix, and an accurate determination of whether the placenta completely or incompletely covers the internal os, depend the choice of procedure. It has been said by a competent authority that “under ideal circumstances and in skilled hands the maternal mortality does not exceed five per cent”. Truly, this alone indicates a very formidable problem.

At the Margaret Hague Maternity Hospital we have treated 181 placenta previas in the past five consecutive years with one death. We follow a definite procedure, which amounts practically to a routine in some respects, after making the proper allowances for the individualization of the cases as needed. Nothing is done, and no vaginal examination is attempted until, or unless, there is on hand and immediately available a suitable *blood donor*, and the operating room is all set up and made ready for a possible abdominal delivery if that is deemed necessary.

This might seem to some as going to extremes in many cases which should not require it. To this, we can only say that we feel that we cannot at all times be certain of just what to expect; and we feel too that our results have amply repaid us for the expense involved and the time expended.

The vaginal examination is made in the operating room, and the amount of bleeding, the type of previa, and the condition of the cervix are made out.

These findings determine whether the problem can be solved by simple rupture of the membranes; or whether there is need for the insertion of a Voorhees bag; or whether one may, with safety, do a version. We might say, in passing, that we do very, very few versions. We attempt no delivery of any kind through a partially prepared cervix. We attempt no forceful delivery of any kind through any type of cervix.

We prefer to do a *Caesarean section* on all cases of complete previa, on all incomplete previas with a coverage of one-half of a cervix of four cm. dilatation, and in the presence of profuse bleeding which continues in a cervix of less than four cm. dilatation.

All that was previously said regarding the very important place ascribed to transfusion in the management of all obstetrical bleeding is reiterated here.

3. RUPTURE OF UTERUS

We have had an unusual experience with rupture of the uterus. Instead of limiting our figures to the past five years, as we have done with the two entities so far discussed, we will review for you the full story of rupture of the uterus as we have seen it since 1931, during which time we have had approximately 40,000 deliveries.

In approximately 40,000 deliveries, there were twenty-four ruptures of the uterus,—an incidence of about one in 1660. Three of these were perforations of the uterus postpartum at the time of diagnostic dilatation and curettage which will not be further analyzed. This leaves twenty-one cases of rupture of the uterus associated with pregnancy.

By rupture of the uterus is understood a solution of continuity of the uterine muscle,

which in all these cases was a complete rupture, involving the entire wall of the uterus out through its peritoneal covering.

Rupture has occurred during pregnancy, i. e., before the onset of labor, in two cases, in both of which there was a spontaneous rupture due to an erosion of a gestation sac implanted, in one instance, in the right cornu of the uterus following, by two years, a tubal pregnancy on that side; and in another instance, a gestation sac implanted in the left cornu. Nineteen of the cases occurred intrapartum, after the onset of labor, the shortest labor being six hours, and the longest thirty-two hours, so that, excluding the two cases which happened postpartum following a diagnostic dilatation and curettage, and the two which ruptured in the cornu, all cases happened after the onset of labor, one of these questionable if before labor.

Six of these nineteen cases had had previous Caesarean section, and had gone into labor.

All authorities point out that the rupture seldom occurs except in a prolonged labor, and usually in obstructed labor. In both conditions one encounters over-distention of the uterus produced by the upper segment working for too long a time against a thinned-out lower segment.

The mode of production of intrapartum rupture is inseparably linked up with the mechanism of the production of the upper and lower uterine segment, and the production of Bandyl's Ring.

The Ring of Bandyl (or abnormal retraction ring) marks the junction of the upper with the lower uterine segment, and is only an exaggerated form of the normal or physiological ring or zone of muscle which marks this juncture.

Bandyl's Ring is due to an obstructive labor, and produces exaggerated thinning of the lower segment and a progressive thickening of the upper. It is caused by obstructed labor, but does not cause the obstruction.

It seems to be that, if the upper segment is not weakened by a previous scar (section), the rupture always occurs in labor and in the lower segment. The rupture may occur (a) *spontaneously*, as in a prolonged labor; or (b) *through intervention*, or intra-uterine manipu-

lation *in a tonic uterus*. Two of our nineteen cases occurred following version in a uterus with a markedly thinned-out lower uterine segment. The three commonest causes of pure spontaneous rupture intrapartum are found in: (1) a contracted pelvis; (2) a neglected transverse presentation; (3) hydrocephalous.

Repeated warnings appear against ill-advised and injudicious intra-uterine manipulation or attempted accouchement force in a tonic uterus.

SYMPTOMS OF RUPTURED UTERUS

The usual picture is that, during the course of labor, sometimes without any great amount of complaint from the patient, shock and internal hemorrhage occur (most likely during a protracted labor). There may be little or no external hemorrhage. Some of our cases had markedly little.

If the rupture occurs during labor and at term, the abdominal findings are quite suggestive. The only other condition which simulates it is abruption of the placenta of the severer type. But in abruptio, usually the intra-uterine or intraabdominal crisis takes place not during labor, but before labor. Some authorities liken the clinical picture of rupture of the uterus at term to that of a ruptured ectopic pregnancy,—shock and intraabdominal hemorrhage.

TREATMENT

All of our nineteen cases had hysterectomies except four, and these had small complete ruptures which were small enough to be repaired and the uterus not removed. None of these died.

Prognosis: There were two living children obtained in these cases, both from previous Caesarean sections.

Maternal Mortality: The two patients with the perforation antepartum both got well. The three with perforation postpartum (following a diagnostic dilatation and curettage) also got well.

Of the nineteen intrapartum ruptures, six women died. One of these deaths was among the six cases complicated by previous Caesarean section.

4. POSTPARTUM HEMORRHAGE

The danger of hemorrhage after the completion of the third stage of labor in the normal case is ever present, and is intimately connected with the proper management of the third stage of labor. It is not our function here to go over the entire ground offered or made possible by this phase of hemorrhage in all its ramifications. We want only to point out some salient points, and to indicate our management of the entity known as *immediate postpartum hemorrhage*.

This type of obstetrical bleeding, in the main, is usually due to one of two causes:

1. To the failure of the uterus normally to retract and contract; or
2. To some injury of the parturient canal bringing about the severance of a reasonably large blood vessel.

In the first place, anything bringing about an overdistention or an abnormal tiring of the uterine muscle will predispose to a failure of the uterus normally to retract. These causes may be multiple pregnancy, hydramnios, protracted labor, and a poor general physical and nervous tone. Prolonged general anesthesia may well be a factor.

The *diagnosis* of the condition is not difficult; and if one has ever seen the severe postpartum type of hemorrhage, he is hardly likely ever to forget it. There is a freer discharge of blood from the vulva, which, instead of rather easy control by fundal massage, becomes worse. The fundus, if that is the site of the bleeding rather than an injured birth canal, feels distended, is soft and does not get hard and firm under stimulation, and with all such fundal manipulation there seems to be an aggravation of the amount of the bleeding.

The rest of the picture is developed in an alarming short period of time—the pallor; rapid feeble pulse; the restlessness; air hunger; the

pinched face; dry lips and tongue; the thin, peaked nose; the rapidly falling blood pressure; the small thready, almost imperceptible, pulse,—all these conditions point infallibly to the extreme gravity of the situation. During the development of this picture, the usual oxytoxics are administered, and as a rule, without much success. Some hope may be entertained for the administration of pitocin or ergotrate intravenously. It should be given slowly, in small doses, and preferably diluted in about ten c.c. of normal saline. This caution applies particularly to pitocin, and does not necessarily apply to ergotrate, which we administer as it is supplied in the ampule.

We have made no use of intrauterine douches for the control of postpartum bleeding. We have but very infrequently made use of intrauterine packing, although personally, if confronted with an alarming emergency, we would not hesitate to use it, making sure to pack the *uterus*, and not merely the vagina, which will do no good whatsoever.

Again, the tremendous importance of transfusion is reiterated with the hope of emphasizing its important place in the management of all bleeding in obstetrics.

It is obvious, of course, that, if the fundus is firmly contracted and well retracted, it must be assumed that the bleeding is not coming from the body of the uterus or the placental site, and that one must therefore look for an injury to the cervix uteri, the vault of the vagina, or to the perineum, or to the bulb of the vestibule, which can bleed furiously if torn. The treatment of all these is *repair* of the injury, and also *transfusion*.

Repeated relaxation of the puerperal uterus may so endanger the life of the woman that no permanent retraction may be expected, and the only safe and certain procedure may be recourse to removal of the uterus.

A LESSON FROM A DEATH CERTIFICATE NUMBER THIRTY

Grav. ii, para i. After fifteen hours of labor it was discovered that a large ovarian cyst obstructed progress. A cesarean was done and cyst removed.

Patient suffered a heart attack and died in 60 hours.

Could the obstruction have been diagnosed before labor or early in labor and a cesarean done before labor or earlier in labor?

A. W. BINGHAM.

STATE SOCIETY ACTIVITIES

DR. LAHEY ADDRESSES THE "TOWN HALL" AUDIENCE

In a plea to let American Medicine work out its own problems without interference, Dr. Frank Lahey, President-Elect of the American Medical Association, helped The Medical Society of New Jersey celebrate its 175th anniversary on March 24 in an address at the Town Hall in Newark. Speaking to 4,000 citizens who filled the Mosque Theatre, Dr. Lahey reminded the audience that life-saving, disease-controlling discoveries had marked the history of medicine in America, and had given the United States the finest medical facilities and medical care in the world. Death rates have been reduced, epidemics wiped out, the average life span prolonged. All these, Dr. Lahey pointed out, were the fruit of the individualized system of medical practice which has characterized the American Way. By contrast, governmentally controlled medicine, as seen in many European countries, has resulted in a conspicuous deterioration of medical service. Dr. Lahey warned against methods of distributing medical care based on the assumption that medical service was a commodity that could be handed out en masse on a cost-plus basis.

The structure of the American Medical Association was described, and its rôle in maintaining high standards in hospitals and medical schools, was emphasized. The chaotic condition that would result if there were no Medical Association was called to the attention of

the audience. Dr. Lahey corrected the popular but unfounded belief that the A. M. A. was hostile to experiments in Group Medicine, stressing the fact that Organized Medicine welcomes such experiments provided only that changes were made cautiously rather than radically, that the insurance plans were supervised by responsible state officials, and that there be no impairment of the patient's freedom to choose his own doctor.

Dr. Lahey devoted a few minutes to a delightful account of recent progress in vitamin medication, chemotherapy, and endocrine surgery. At the conclusion of his talk, the audience, in the traditional Town Hall manner, submitted queries to the speaker. In response, Dr. Lahey indicated that he favored passage of the Murray Bill to defer the conscription of medical students. He felt that competition among physicians was a wholesome stimulant to medical progress, and was doubtful if the placing of doctors on a salary would improve medical care. He stated that many apparent defects in the distribution of medical service were really defects in the distribution of such essentials as food, clothing and housing.

Dr. Watson B. Morris, President of The Medical Society of New Jersey, was chairman of the Forum, and Dr. Charles M. Robbins, Public Relations Committee Chairman, presided over the question-and-answer period.

POST-GRADUATE EDUCATION

Enclosed in this issue of the Journal is a self-addressed, stamped postcard relative to Post-Graduate Education. It is hoped that each doctor will answer the questions on this card and return it at his earliest convenience. No signature is required.

The purpose of the card is to ascertain the wishes and needs of our members in Post-Graduate Education. The information gained will be used by the State Committee and rec-

ommendations will be transmitted to the County Societies to further the work of their Post-Graduate Committees. From recent requests and questions received, it seems that there are still source of Post-Graduate Education which have not been tapped, and subjects on which some of our members wish further instruction.

If any individual has additional suggestions which he would like to transmit directly, please feel free to write to the committee.

ATTENTION!

All Physicians in New York, New Jersey, and Connecticut

Please send in your *Directory Card* NOW so that the 1941 edition of the *Medical Directory of New York, New Jersey, and Connecticut* may have your personal data accurate. Deadline for copy is near.

MEDICAL SERVICE ADMINISTRATION

SPONSORED BY THE MEDICAL SOCIETY OF NEW JERSEY

By HARRY N. COMANDO, M.D., F.A.C.S., President, Essex County Medical Society

Our major project this year is Medical Service Administration. This is your plan, and its successful operation yields double-barrelled benefits to you. First, there is the direct benefit of your keeping as private patients a large group of families who would otherwise drop into the clinic or ward-patient category. Second, the indirect benefit that accrues to all doctors by showing the public that organized medicine is concerned with meeting the problem of properly distributing medical care. And over and above these personal benefits to us, the Plan is a token of our willingness to give a service to the public.

The money is now available to initiate the project. What is needed is the participation of 51 per cent of the M.D.'s in each county. Without such participation the Plan is legally estopped from operating. There is nothing in this Plan to which any practitioner can object.

Some strange and spurious notions are keeping a few physicians from signing the participating agreement. One fear is that the doctor will have to accept patients whom he might otherwise reject; perhaps that he might have to make night calls when he ordinarily excludes such calls, etc. Let it be said here and now that this is not the case. The Administration not only preserves free choice of physician, but it also preserves the doctor's right to free choice of patient. You are neither morally nor legally obliged to accept anyone under the plans. If you wish, you can see only office patients, and send your associate to make calls. You can bar from your practice any kind of patient you ordinarily exclude. And since the Plans are not available to those in upper or

high-middle income brackets, it will not disturb your relations with these private patients.

A second fallacy is the fear that a specialist will be obliged to take work outside his specialized area. This again is not the case. Since you have free choice of patient, you can refuse practice beyond the scope of your specialty.

Nor need you fear that the Medical Service Administration will in any way dictate your methods of treatment. Indeed, Chapter 74 of the Law reads: "The Administration shall not impose any restrictions on physicians as to methods of diagnosis or treatment."

For further details of the plan, re-read the information in recent issues of this Journal. Better yet, read carefully the Supplement in the February Journal. Having done this you will want to sign the participating agreement. Let me cite the last paragraph of the article in the February *Bulletin* of Essex County Medical Society:

"If you forget to sign the participation agreement, you can not share in the benefits of the Plans. If you do sign, your relations with patients in the middle income brackets are unchanged, but you will be able to retain as private patients those subscribers in the low-wage group who might otherwise become ward or clinic patients."

Medical Service Administration is your project! We physicians drafted it, asked the Legislature to enact it. Only fully licensed doctors may participate. Cultists are excluded. We have worked for this for several years. Now it is here; let us use it!

This article, based upon an announcement in the Essex County Medical Society Bulletin of March, 1941, is reprinted with minor alterations with the permission of Dr. Comando.

CHILD WELFARE EXHIBIT

The Child Welfare Committee of the Essex County Medical Society is conducting an exhibit entitled "Your Child and Its Care" in the Newark Museum, at 43 Washington Street, Newark, N. J.

The exhibit will be open to the public on week days from 2 to 5 p. m.; and on Sundays from 2 to 6 p. m. It began on March 18, and will continue through May 18.

The exhibit includes many interesting fea-

tures, including a complete premature unit, a model of an ideal infant nursery, a demonstration of an infant resuscitator, various vaccines and sera used in preventive medicine, illuminated photographs demonstrating the work done in the Baby Keep-Well Stations, and picture studies illustrating graphically the study of infant conduct and care.

HARROLD A. MURRAY, M.D.

PARTICIPATING PHYSICIANS MEDICAL SERVICE ADMINISTRATION

APRIL, 1941

Counties	A. M. A. Count			Total No. of Agreements Received to Date	Counties in Which 51% Have Enrolled
	Total No. of Physicians	Tot. No. Private Practice	Total No. Co. Med. Soc.		
Atlantic	195	171	126	66	
Bergen	403	348	272	183	X
Burlington	105	86	60	45	X
Camden	283	247	177	132	X
Cape May	38	30	24	16	X
Cumberland	73	67	55	25	
Essex	1,435	1,238	859	782	X
Gloucester	64	58	41	36	X
Hudson	795	636	439	209	
Hunterdon	42	37	24	15	
Mercer	303	230	202	154	X
Middlesex	197	177	129	48	
Monmouth	221	178	141	41	
Morris	166	107	105	59	X
Ocean	46	41	27	22	X
Passaic	431	387	300	104	
Salem	38	36	23	21	X
Somerset	101	67	60	36	X
Sussex	31	27	20	15	X
Union	416	362	304	184	X
Warren	50	44	36	24	X
Outside of State ...					
Totals	5,433	4,574	3,424	2,217	

On March 25, 1941, Medical Service Administration received its Certificate of Authority from the Commissioner of Banking and Insurance. It is qualified and licensed to operate in fourteen counties.

County qualification means that 51 per cent of the active physicians of that county have signed the "Agreement of Participating Physician." The number of physicians in private practice by counties is shown in the third column of the above table. In the last column are designated the qualified counties.

Please sign the Participating Physician's Agreement distributed with this issue of the Journal and return it to 143 East State Street, Trenton, N. J. A discussion of this Agreement appears on page 141 of the March issue of the Journal.

WARNING REGARDING SULFATHIAZOLE TABLETS

Please examine immediately every stock container of *Sulfathiazole Tablets* 0.5 gm. bearing the label of the

WINTHROP CHEMICAL COMPANY

Look for Control Number *M P 0 2 9*. The Control Number is located on the front label of the bottle at the top right-hand corner just above the Caution statement, and is printed in blue.

If you have a bottle of these tablets *bearing this number* in your stock, notify this office at once, and under no circumstances use or dispense any of these tablets.

Your immediate and complete coöperation is requested in the interest of the public health.

The Board of Pharmacy of the State of
New Jersey
ROBERT P. FISCHER, Secretary

MEDICAL PREPAREDNESS

The following questions submitted by County Chairmen were referred to the Office of the Surgeon General and answered in a letter received March 29, 1941:

1. "First, have any doctors (M.D.) been inducted into the Army in non-professional capacities?"

Answer: I have inquired from the Personnel Division and have been informed that they have a record of at least six. Two of these have been appointed in the Medical Reserve Corps: One a selectee from Honolulu; the second a selectee who was 62½ inches in height who had been rejected previously for appointment in the Medical Reserve Corps. He was subsequently inducted and then given a commission when height for the Medical Reserve Corps was reduced to 60 inches. There is no record of the status of application for appointment in the Medical Reserve Corps of the others.

2. "Assuming that a physician had applied for a commission in the Medical Corps and rejected on physical grounds which would place him in Class 1-B, would he then be inducted as a 1-B draftee?"

Answer: Under the present physical standards he would be placed in Class 1-B. However, it would appear that if it become necessary to accept Class 1-B registrants some effort should be made to permit the appointment of certain categories of officer candidates whose physical qualifications fall in that group.

3. "Assuming that a physician in the draft age had applied for a commission and was found physically qualified but informed that

none were being issued at present, would this be grounds for deferment until commissions were being issued?"

Answer: Deferment is entirely a function of Selective Service. It is probable that local boards would grant reasonable delay pending appointment. I believe it should be emphasized that registrant physicians who have no dependents and are physically qualified make immediate application for appointment in the Medical Reserve Corps. If they wish to take their chances and are selected they will have no alternative than to serve several months in an enlisted status, and if then appointed in the Medical Reserve Corps they will have to serve an additional twelve months as a medical officer.

4. "Are the physical standards for commission in the Medical Corps any more exacting than those for draftees?"

Answer: Yes. I am enclosing copies of Mobilization Regulation 1-9, and Army Regulations 40-105, including Changes 5. A comparison of these regulations will show the difference in physical requirements. However, if a physician meets the physical requirements of Mobilization Regulations 1-9 and is inducted into the service under the Selective Service Act, and then applies for a commission, every effort would be made to give him a commission in the Medical Reserve Corps even though he did not meet the physical requirements of Army Regulations 40-105.

5. "Is it not true that applicants for commission in the Medical Corps may be acceptable in the presence of minor physical defects if they sign waivers?"

Answer: No.

THE STATE SOCIETY AWARD, 1941

The Medical Society of New Jersey has authorized an award of one hundred dollars for the best essay on an original medical subject, submitted according to the following rules:

1. Any medical or surgical subject may be selected.

2. The essay must be unpublished and of interest to the general practitioner.

3. Contributions must come from members of the Society who are in good standing.

4. The manuscript must not exceed 5000 words; and shall be typewritten in English, in manuscript form, with double spacing, wide margins and be

written on one side of the page, and five copies shall be submitted.

5. Manuscripts must be in the office of the Secretary of the State Society, Dr. Alfred Stahl, 55 Lincoln Park, Newark, N. J., not later than April 15, 1941.

6. The winner shall be determined by a secret Awards Committee composed of five members of The Medical Society of New Jersey. The officers of the State Society are not eligible for the award.

7. The winner shall be awarded a cash prize of \$100; and an invitation to present the contribution before the 1941 Annual Meeting of the State Society.

8. The Society reserves the right to make *no award*, if in the judgment of the committee no contribution is desirable.

AMERICAN COLLEGE OF PHYSICIANS

The American College of Physicians will hold its twenty-fifth annual session in Boston, Massachusetts, April 21-25, 1941. The Registration Bureau will be in the Hotel Statler, near the Boston Common.

The scientific sessions will be held every

morning and afternoon, with social events in the evening.

There will be clinics and demonstrations in the several hospitals of Boston, and panel discussions will be held daily at noon. An extensive series of technical exhibits will be an attractive feature of the session.

NORTHERN NEW JERSEY DERMATOLOGICAL SOCIETY

Reported by C. C. Carpenter, M.D., Summit, N. J., Secretary

NUMMULAR ECZEMA

At a meeting of the *Northern New Jersey Dermatological Society*, held at the Academy of Medicine in Newark on February 19, 1941, with Dr. N. B. Heller presiding, the subject of nummular or orbicular eczema was discussed. This condition is relatively common, but there is very little mention made of it in the textbooks. It is characterized by the appearance of itchy, pin-head-sized vesicles, usually first present on the back of the hands. The vesicles gradually spread peripherally to form definite circular lesions. Other lesions occasionally appear on the arms and legs. Usually this condition is very difficult to treat, and has a great tendency to recur. A seasonal factor of occurrence in the Winter is found in the majority of cases, and is further promoted by exposure to strong cleansing agents, and by excessive scratching. It was also brought out that occasionally these cases show an abnormality in their sugar metabolism, and that, if this is definitely proved, such patients will improve with proper diet. Individuals suffering from this condition may also have sensitivities to other sub-

stances which apparently do not have anything to do with the direct cause, as may be seen in industries where resins, chemicals, and synthetics are used. It was the opinion of the members that a worker with this type of eruption would be better removed from these occupations.

Nummular eczema is frequently confused with parasitic eczema from an unknown fungus; and also with seborrheic eczema.

As to the treatment for this condition, it should be directed to soothing the itching by bland ointments, removing any contact irritants, and employing a diet low in carbohydrates. The most advantageous method of treatment is small daily dosages of ultraviolet light.

In addition to this discussion, several very interesting and unusual cases were presented. It was reported that three of our members, Dr. Solomon Greenberg, of Bayonne; Dr. Joseph Kwint, of Plainfield; and Dr. Morris Saffron, of Passaic, were in active service with the Army.

NUMBER OF CHILDREN REPORTED RECEIVING FREE STATE BIOLOGICALS
SINCE JULY 1, 1940

DIPHThERIA TOXOID

County	Total to Jan. 31	Month of Feb.	Total to Feb. 28	Average per Month
Atlantic	7013	131	7144	893.
Bergen	1686	101	1787	223.3
Burlington	305	0	305	38.1
Camden	1043	93	1136	142.
Cape May	21	2	23	2.8
Cumberland	71	2	73	9.1
Essex	5436	660	6096	762.
Gloucester	71	10	81	10.1
Hudson	1859	466	2325	290.6
Hunterdon	106	0	106	13.2
Mercer	1372	66	1438	179.7
Middlesex	371	207	578	72.2
Monmouth	960	1	961	120.1
Morris	400	8	408	51.
Ocean	150	27	177	22.1
Passaic	2959	248	3207	400.8
Salem	202	1	203	25.3
Somerset	238	7	245	30.6
Sussex	3	0	3	.3
Union	1244	28	1272	159.
Warren	54	7	61	7.6
Totals	25564	2065	27629	3453.6

SMALLPOX VACCINE

County	Total to Jan. 31	Month of Feb.	Total to Feb. 28	Average per Month
Atlantic	648	21	669	86.1
Bergen	1085	51	1136	142.
Burlington	245	0	245	30.6
Camden	1271	16	1287	160.8
Cape May	54	0	54	6.7
Cumberland	124	0	124	15.5
Essex	4996	210	5206	650.7
Gloucester	202	7	209	26.1
Hudson	2209	105	2314	289.2
Hunterdon	21	0	21	2.6
Mercer	852	134	986	123.2
Middlesex	612	235	847	105.8
Monmouth	349	4	353	44.1
Morris	494	7	501	62.6
Ocean	21	0	21	2.6
Passaic	1902	204	2106	263.2
Salem	233	0	233	29.1
Somerset	139	4	143	17.8
Sussex	21	0	21	2.6
Union	1093	18	1111	138.8
Warren	190	1	191	23.8
Totals	16761	1017	17778	2222.2

OBITUARIES

DR. ARTHUR W. BELTING

Dr. Arthur W. Belting, Trenton, N. J., died suddenly on March 24, 1941, aged 63 years, from a heart condition. He graduated from the Hahnemann Medical College, Philadelphia, in 1903; and since that time he has practiced medicine in Trenton.



Dr. Belting served on the Board of Medical Examiners of the State of New Jersey, and was its president. He was on the Medical Staff of McKinley Hospital, Trenton, and was active in the Boy Scouts' organization.

sex County. In 1882 he won a scholarship to West Point, but took an honorable discharge in order to study medicine. He graduated from Bellevue Medical School in 1888 and interned in the Paterson General Hospital. At the time of his death he was a member of the Medical Staff of Barnert Memorial Hospital. At one time he was a member of the Board of Directors of the hospital at Morris Plains. Dr. Gillson was a past president of the Passaic County Medical Society.

DR. CLARENCE L. VREELAND

Dr. Clarence L. Vreeland, of Pompton Lakes, Passaic County, died on February 21, 1941, from pneumonia, aged 64 years. He was descended from early settlers from Holland. He graduated from the College of Physicians and Surgeons, New York City, in 1900, and practiced in Pompton Lakes for twenty-seven years.

During the World War he served as Major in the U. S. Army Medical Corps, and was in active service in the Argonne offensive.

Dr. Vreeland was well liked by his medical colleagues; and the members of the Medical Society of Passaic County adopted resolutions expressing their appreciation of his comradeship and public services.

DR. HENRY H. BREVOORT

Dr. Henry H. Brevoort, aged 65 years, of Lodi, N. J., died on March 24, 1941, following a heart attack. He was born in Passaic on September 21, 1876. He graduated from the University of Michigan in 1900, and since graduation has practiced in Lodi. He was Medical Inspector of the public schools and Health Officer of Lodi for 25 years. For many years he headed the Red Cross Committee of his community. Dr. Brevoort, a member of the Passaic County Medical Society, was the last of Lodi's "horse and buggy" doctors. He died in the active practice of his profession, of which he was an honored and competent member.



Dr. Brevoort, a member of the Passaic County Medical Society, was the last of Lodi's "horse and buggy" doctors. He died in the active practice of his profession, of which he was an honored and competent member.

DR. ROGER W. MOISTER

Dr. Roger W. Moister, of Summit, died on March 9, 1941, in Phoenix, Arizona, aged 64 years.

Dr. Moister graduated from the New York College of Homeopathy in 1902, and was Senior Attending Obstetrician in the Overlook Hospital, Summit.

The following memorial was adopted by the Summit Medical Society:

"Dr. Moister was a man unusually loved by his patients, to whom he devoted all his best ability. He was progressive, ambitious, tireless, generous and kind. He had a never-failing sense of humor, and everyone with whom he came in contact felt the uplifting impact of his personality. He encouraged the younger practitioners by word and deed, and was always ready to give them active assistance."

DR. JOHN T. GILLSON

Dr. John T. Gillson of Paterson, aged 79 years, died on March 23, following a complication of illnesses. Dr. Gillson, one of Paterson's oldest and best-known medical practitioners, was born in Sussex County.

DECEASED PHYSICIANS — NEW JERSEY

Name	Age	Date of Death	Place of Death	Residence	Cause of Death
Edward J. Pendergast	67	Feb. 8, 1941	Jersey City	Same	Chronic myocarditis.
George B. Spath	66	Feb. 26, 1941	Hoboken	Same	Myocardial insufficiency.
Clarence L. Vreeland	63	Feb. 21, 1941	Pompton Lakes	Same	Chronic myocarditis.

COUNTY SOCIETY REPORTS

COUNTY SOCIETY COMING MEETINGS

APRIL, 1941

1 Camden	10 Passaic
1 Hudson	10 Somerset
8 Bergen	11 Atlantic
8 Cape May	15 Warren
8 Cumberland	16 Middlesex
9 Mercer	17 Gloucester
9 Ocean	18 Salem
9 Union	22 Hunterdon
10 Burlington	23 Monmouth
10 Essex	

MAY, 1941

6 Camden	13 Sussex
6 Hudson	14 Mercer
8 Burlington	14 Middlesex
8 Essex	14 Ocean
8 Passaic	14 Union
8 Somerset	15 Gloucester
9 Atlantic	16 Salem
13 Bergen	28 Monmouth
13 Cape May	

ATLANTIC COUNTY

Charles Hyman, M.D., Reporter

The regular monthly meeting of the *Atlantic County Medical Society* was held at the Ambassador Hotel, Atlantic City, on Friday, March 14, 1941. The meeting was called to order by the President, Dr. V. Earl Johnson, at 9 p.m.

SCIENTIFIC

The scientific paper entitled "Gangrene—Its Diagnosis, Prevention, and Management" was given by Dr. David W. Kramer, Assistant Professor of Medicine, Jefferson Medical College, Philadelphia, Pa. The various types of gangrene were enumerated and demonstrated by lantern slides, and the points in their differential diagnosis were discussed. Dr. Kramer emphasized the importance of proper care of the feet in diabetics as a preventive measure, and reviewed some of the newer methods of therapy. The paper was discussed by Drs. Scanlon, Salasin, Allman, Rise, Barbash, Johnson, and Read.

COMMITTEES

Committee reports were made by Drs. Scanlon on Insurance; Davidson, on Cancer; and Allman, Insurance and Legislation.

The Society voted to cooperate with the Press-Union in publishing a supplement to the newspaper during the Annual Meeting of the State Society, May 20-22, 1941.

CAMDEN COUNTY

Harold D. Barnshaw, M.D., Reporter

The regular meeting of the *Camden County Medical Society* was held in the City Dispensary Building, Camden, on February 4, 1941.

SCIENTIFIC

This was a case report meeting, and interesting patients were described and discussed. Dr. Hyman Goldstein presented "Interesting Ulcers of the Stomach"; and Dr. Paul Mecray, Jr., "Multiple Polyposis of the Colon".

MEDICAL SERVICE ADMINISTRATION

Dr. Norman M. Scott, Medical Director of the Medical Service Administration, explained the necessity of signatures of 51 per cent of the practitioners in order that the Administration may operate in Camden County. The society voted its approval of the Administration.

MEMBERSHIP

Donald J. Volpe, Audubon; Leland M. Stetser, Collingswood, and Leopold S. Lipsitz, Camden, were admitted to active membership.

CAPE MAY COUNTY

By Clarence W. Way, M.D., Reporter

A regular meeting of the *Medical Society of Cape May County* was held at the Ocean City Country Club, Somers Point, N. J., at 7:00 p.m., Thursday, March 13, 1941. This was the second annual dinner of the Cape May County Bar Association and the Medical Society of Cape May County. (See Jour., June, 1940, p. 338.)

County Solicitor Robert K. Bell, of Ocean City, presided, and introduced Charles K. Landis, Jr., of Sea Isle City, President of the Cape May County Bar Association, who paid a beautiful tribute to the medical profession. Mr. Bell also introduced Judge Howard Sharp, of Cumberland County; Judge Robert Warke, of Atlantic County, and Judge Palmer M. Way, of Cape May County.

Dr. Aldrich C. Crowe, Ocean City, President of the Medical Society of Cape May County, presented the following visiting physicians:

Dr. Vincent Butler, Jersey City, Councilor of the Second District

Dr. Harry B. Diverty, Woodbury, President of the Gloucester County Medical Society

Dr. Charles Butcher, Heislerville, President of the Cumberland County Medical Society

Major General B. D. Foulois, Atlantic City, former Chief of the U. S. Air Corps

Dr. James F. Norton, Jersey City, Trustee, State Medical Society

Dr. Harry R. North, Trenton, Trustee, State Medical Society

Dr. Norman M. Scott, Executive Assistant,
State Medical Society

Dr. J. H. Underwood, Woodbury

Dr. D. Ward Scanlon, Atlantic City.

Mr. Bell also introduced Judge Herbert F. Goodrich, former Dean of the University of Pennsylvania Law School, and now judge of the Third District Court of Appeals. Judge Goodrich pointed out the similarity between the mental action of the judge and that of the doctor, in deciding questions by the evidence that is presented.

Dr. Edward A. Stricker, Professor of Psychiatry at the University of Pennsylvania Medical School, spoke on "A Psychiatric Perspective on the World Situation". He attributed the present conflict to mass psychology. He branded propaganda as the greatest menace to civilization.

ESSEX COUNTY

By Paul H. Hosp, M.D., Reporter

The *Essex County Medical Society* held its regular monthly meeting in the Academy of Medicine on March 13, 1941, at 9 p.m., with the President, Dr. Harry Comando, presiding.

MEMBERSHIP

Dr. Lucile F. Miller, Newark, was elected to active membership, and Drs. Edgar M. Braun, Newark, and Nicholas M. Kelemen, East Newark, were elected associate members.

SCIENTIFIC

Dr. Jerome Samuels presided at the scientific session of the meeting, and introduced Dr. William H. Schmidt, Assistant Professor of Physical Therapy in the Jefferson Medical College, Philadelphia, who spoke on "The Use of High Frequency Current in Medicine and Surgery".

125TH ANNIVERSARY

A special feature of the meeting was the celebration of the 125th anniversary of the founding of the Essex County Medical Society on June 4, 1816. In accordance with the law of February 16, 1816, The Medical Society of New Jersey appointed "Doctors Quimby, S. Manning, Craig, P. Elmer, and Williams, to meet on the first Tuesday in June next, at 10 o'clock a.m., for the purpose of appointing a County or District Society for the County of Essex". (First Minute Book of the State Society, page 150.)

The special historical exercises consisted in the presentation of resolutions of appreciation to twenty physicians who had been members of the Society for over half a century. The list was as follows:

Becker, Frederick W.	Halsey, Levi W.
Bradshaw, John H.	Hawkes, Edward Zeh
Brien, William M.	Hexamer, Fred
Chapman, Robert W.	Ill, Edward J.
Christian, A. C.	Lane, Frank B.
Clark, J. Henry	Matthews, Harry E.
Cooke, William H.	Morris, Clement
Eagleton, Wells P.	Morrison, Caldwell
Foster, William S.	Wallhauser, H. J. F.
Freeman, Richard S.	Wolfe, Jacob S.

These members had been entertained by the Society at a supper in the Essex House previous to its regular meeting.

THE ACADEMY OF MEDICINE OF NORTHERN NEW JERSEY

Franklin J. Tobey, M.D., Secretary

The Thirtieth Anniversary of the *Academy of Medicine of Northern New Jersey* was observed at the stated meeting, Thursday, March 20, 1941, with the President, Dr. Charles M. Robbins, presiding.

The report of the Nominating Committee, Drs. William H. Areson, chairman; Harry N. Comando and Royal A. Schaaf, was read by the chairman.

For President (2 years), Edward W. Sprague, M.D., Newark.

For Vice-President (2 years), John W. Gray, M.D., Newark.

For Treasurer (2 years), Lee W. Hughes, M.D., Newark.

For Secretary (2 years), Franklin J. Tobey, M.D., Newark.

For Trustees (5 years), Erwin Reissman, M.D., Newark; Henry B. Orton, M.D., Newark; Charles M. Robbins, M.D., Newark.

For Committee on Admission, (5 years) Jerome G. Kaufman, M.D., Newark; (3 years) H. Roy Van Ness, M.D., Newark.

For Committee on Library, (5 years) Archer C. Bush, M.D., Newark; (1 year) Sigmund Kaswimer, D.D.S., Newark.

There being no nominations from the floor, a motion to close the nominations was made, seconded and passed. The election of these officers will be held at the April stated meeting.

Dr. Robbins welcomed the guests of the physicians present and asked that they stand for a minute in silence in memory of the deceased Presidents of the Academy, Gordon K. Dickinson, August A. Strasser, John F. Hagerty and Charles L. Ill.

Dr. Robbins read a letter from Governor Edison, who was unable to be present, wishing the Academy continued success in the scientific work that has been so ably conducted during the last thirty years and thanking the Academy for their service to the public in maintaining a medical library.

Dr. Robbins presented "A History of the Academy of Medicine, 1911-1941," illustrated by lantern slides of the city, its hospitals, its doctors and the customs of thirty years ago. Many of the youthful doctors so pictured were present. The contrast with the present city and hospitals was amazing even to those present who have witnessed the changes. The audience enjoyed the story and showed their appreciation by hearty applause.

The president introduced the guest speaker, Dr. Hugh H. Young, Professor of Urology, Johns Hopkins University. Dr. Young said he greatly enjoyed being present on such an occasion and spoke of his "reminiscences" with Halsted, Kelly and Osler in Baltimore. He related his experiences in the Army of the last World War, many of which were extremely amusing as well as enlightening.

The meeting adjourned with a rising vote of thanks to our guest.

PROGRAM FOR APRIL, 1941

Medicine and Pediatrics Section, Tuesday, April 8, 1941, 8:45 p. m.

Paper: "Immunizations in Pediatric Practice" (with special reference to the prophylactic treatment of measles and scarlet fever). Samuel Karelitz, M.D., Adjunct Attending Pediatrician, Mt. Sinai and Willard Parker Hospitals, New York City; Associate in Pediatrics, College of Physicians and Surgeons, Columbia University.

Discussion opened by Ellis L. Smith, M.D., Superintendent, Essex County Hospital for Contagious Diseases.

Eye, Ear, Nose and Throat Section, Monday, April 14, 1941, 8:45 p. m.

Paper: "Deep Infections of the Neck" (illustrated). Henry B. Orton, M.D., Professor of Laryngeal Surgery, New York Polyclinic Medical School and Hospital.

Stated Meeting, under the auspices of the Section on Obstetrics and Gynecology, Thursday, April 17, 1941, 8:45 p. m.

Paper: "Treatment of Separation of the Placenta with Spanish Windlass and Packing" (illustrated). Frederick C. Irving, M.D., William Lambert Richardson Professor of Obstetrics, Harvard Medical School.

A Conference of the State Maternal Welfare Committee, the Maternal Welfare Committees of the Counties and all Field Physicians of New Jersey will be held at the Academy of Medicine in the afternoon. Field Physicians at 3 p. m., Maternal Welfare Committees at 4 p. m. Informal dinner at the Essex House, 1050 Broad Street, Newark, at 7 p. m.

Physicians are invited to attend the conference and the dinner. Arthur W. Bingham, M.D., Chairman, Maternal Welfare Committee of New Jersey.

Special Meeting, under the auspices of Physicians and Pharmacists, Wednesday, April 23, 1941, 9 p. m.

Papers: "Relationship Between Physicians and Pharmacists." Robert P. Fischelis, Phar. D., Secretary, New Jersey State Board of Pharmacy. Chester I. Ulmer, M.D., Chairman, Joint Committee on Professional Relations.

Forum: Discussion of Joint Problems.

Charles M. Robbins, M.D., President of the Academy, will preside.

GLOUCESTER COUNTY

C. A. Bowersox, M.D., Reporter

The monthly meeting of the *Gloucester County Medical Society* was held at the Woodbury Country Club on March 20, 1941. Dr. Henry B. Diverty, President of the Society, presided.

LEGISLATIVE COMMITTEE

Dr. Wendell Burkett, Chairman, presented a digest of all the bills now being presented in Trenton concerning the medical societies of the State.

MEDICAL PREPAREDNESS

Dr. William Pedrick presented a definite plan for action by the Gloucester County Medical Society in a serious emergency, either war or a widespread calamity. He stated that there has been some confusion in selecting physicians for the local draft boards, some of which are directly chosen by military units. He believes that the Medical Preparedness Committee should have some part in selecting its own draft board members, and that they should be approved by military units. On motion of Dr. Hollinshed, the Society approved the Medical Preparedness Act, and also the principle that the committee nominate the members to serve on the local examining board.

PUBLIC RELATIONS

Dr. Collins gave his report on the assignment of speakers throughout the county in the past month. The Kiwanis Clubs in New Jersey are planning a group of programs called "The American Way". During the month of October, for one week, this club is planning to have a speaker come from the Medical Society to discuss the medical problem.

MEDICAL SERVICE ADMINISTRATION

Dr. Chester I. Ulmer then reported on the progress made in having the participating physician agreements for the Medical Service Administration signed by members of the society. Our quota has already been filled; but he stated that if the society recommends such service, it will demonstrate to the people of New Jersey that the Medical Society can administer its own affairs.

SCIENTIFIC

Dr. Thomas Shallow, Professor of Surgery at Jefferson Medical College, gave a talk on "The Infections of the Hand". He stated that each finger represents a definite unit. The function of the hand is most important in the occupation of the present-day laborer. The essentials in treating infections of the hand are:

1. The hand must be restored to the same condition that it was in before the injury.
2. The thumb is the most important part of the hand.
3. The index fingers are second in importance.
4. A felon is not primarily an infection of the distal phalanges; it is a result of a bruise, plus infection, the bacteria gaining entrance through an abrasion, and the infection becoming enclosed in the distal end of the finger. The supply of blood is then obstructed, and a lack of nutrition then results.

5. Infections which involve the tendons should be incised as soon as possible in order to prevent dead tissue from forming.

Dr. Shallow then presented some reels of moving pictures and slides of the various methods of treatment of infections in the different parts of the hand.

After a most interesting discussion by the members of the society, the meeting adjourned.

HUDSON COUNTY

John N. Connell, M.D., Reporter

A regular meeting of the *Hudson County Medical Society* was held on Tuesday, March 4, 1941, at 9:25 p.m., in the Masonic Club, Jersey City, with the President, Dr. G. Ginsberg, presiding.

The Nominating Committee presented its report.

SCIENTIFIC

Dr. B. S. Pollak introduced J. Arthur Myers, Ph.D., M.D., F.A.C.P., Professor of Medicine and Preventive Medicine and Public Health, University of Minnesota; Chief of the Medical Staff of Lymanhurst Health Center, Minneapolis, who spoke on "The General Practitioner's Part in the Program of the Prevention and Control of Tuberculosis".

Discussors: Drs. A. E. Jaffin, B. P. Potter, Joseph R. Morrow, Medical Director of Bergen Pines, and John E. Runnels, Medical Superintendent of Union County Tuberculosis Hospital.

Dr. Perez, Associate Professor of Medicine at one of the Medical Schools in Argentina, was introduced to the Society.

MEMBERSHIP

One candidate was proposed for membership.

Three new members were elected:

David K. Ricks, Jersey City
Robert Montfort, Jersey City
Fred Seligman, Union City

OFFICIAL VISIT

Dr. Watson B. Morris, Springfield, President of The Medical Society of New Jersey, called attention to the meeting in the Town Hall, Newark, on May 24, in celebration of the 175th anniversary year of the State Society.

Dr. Morris also called attention to the Annual Meeting of the State Society on May 20-22, and especially to its historical features.

MEDICAL SERVICE ADMINISTRATION

Dr. Norman M. Scott, Medical Director of the Medical Service Administration, called attention to the essential features of the Plan, and the requirement that 51 per cent of the practicing physicians of a county must sign a participating agreement before the Plan can be operated in that county.

MIDDLESEX COUNTY

By Cyril I. Hutner, M.D., Reporter

The March meeting of the *Middlesex County Medical Society* was held at the Roosevelt Hospital, Metuchen, on March 19, 1941, with the President, R. J. Faulkingham, presiding.

SCIENTIFIC

Dr. Bernard I. Comroe, Associate Professor of Medicine of the University of Pennsylvania Medical School, spoke on "The Practical Points in the Diagnosis and Treatment of the Various Forms of Arthritis". The paper was excellently presented by Dr. Comroe and was thoroughly enjoyed by the Society. Dr. Trudson discussed the paper.

MEMBERSHIP

Dr. B. Friedenthal, New Brunswick, was elected to full membership.

POST-GRADUATE EDUCATION

Dr. I. J. Fine, Chairman of the Post-Graduate Committee, announced that the lectures will begin on Thursday, April 10, 1941, at 9 p.m., and will continue for six weeks. The first three lectures will be given at the Perth Amboy General Hospital, Perth Amboy, and the last three, at St. Peter's General Hospital, New Brunswick. These lectures are free to members and associate members of the Middlesex County Medical Society.

WOMAN'S AUXILIARY

Dr. Rothfuss, Chairman of Woman's Auxiliary Committee, was informed that June was the only available month for the dance.

OUTING

Dr. Sherman reported that the joint meeting with the Dental Society would conflict with the State Society Annual Meeting. A motion was made and passed that the date of the May meeting be changed from May 21 to May 14.

COMMUNICATIONS

1. From Medical Service Administration, February 19, that an Advisory Committee is to be appointed by the Society for one year, the majority of the committee to be physicians.
2. From Medical Service Administration, March 18, that not enough doctors have signed up in Middlesex County; more doctors are requested to sign up.
3. A post-graduate course in pulmonary tuberculosis is being given by the Hudson County Medical Society April 4 to April 25.
4. Princeton Film Center has British war films available for rental. They are 16-mm. sound films and useful in aiding National Defense.

The meeting was ordered adjourned and members invited for refreshments in the cafeteria.

MONMOUTH COUNTY

Murray Woronoff, M.D., Reporter

A joint meeting of the *Monmouth County Medical Society* with the *Monmouth County Bar Association* was held at the Berkeley-Carteret Hotel, Asbury Park, on Tuesday evening, March 25, 1941.

PROGRAM

The program was divided into two parts. The first part was the presentation of two papers, "The Relationship of the Doctor and Lawyer in Court", by Dr. D. F. Featherston, and "Evaluation of Injuries", by Dr. O. R. Holter. These papers were very interesting and were enjoyed by all present.

The second portion of the program was entertaining and instructive. It consisted of a panel of experts made up of three physicians and three lawyers. Written questions were passed up from the floor and were read by Dr. Fisher. He assigned the questions to one or more of the experts for their

answer. The meeting was very pleasant and was attended by about three hundred people.

Dr. Watson B. Morris, President of the State Society, was guest.

MEMBERSHIP

Three applications for membership and one for associate membership were received.

PASSAIC COUNTY

Irving Okin, M.D., Reporter

The regular monthly meeting of the *Passaic County Medical Society* was held on March 13, at 9:00 p.m., at School No. 13, Dr. Frank W. Ash presiding.

The following new members were elected:

Active Membership:

Ezra Schlossberg, Passaic

Associate Membership:

Dorothy K. Klughaupt, Passaic

Peter William Ross, Passaic

PREVENTION OF BLINDNESS

The report of the Committee on the Prevention of Blindness was read by Dr. Thomas A. Sanfacon and adopted. The report follows:

"We recommend that all eye clinics in Passaic County be under the complete charge of an ophthalmologist, including refraction and skiascopy.

"We are opposed to an optometrist conducting or refracting in any eye clinic in Passaic County, even though the optometrist is working in conjunction with a physician, because of the following reasons:

"a. An optometrist is not trained to recognize and diagnose the wide variety of eye diseases as well as a trained eye physician.

"b. We recognize that an optometrist is licensed by the State to do refraction and skiascopy without the aid of drugs; but we also recognize that a competent refraction and skiascopy in many cases cannot be done accurately and completely without the use of drugs.

"c. The fact that an optometrist is licensed by law does not imply that his method is the accepted method to examine eyes, or that it is thoroughly equal or as complete as the medical way of eye examination. It rather implies that the method is safe *as far as it goes* in examining eyes.

"d. Refraction and skiascopy are part of the whole medical survey, and are not to be treated separately or relegated to an optometrist if best judgment, undivided responsibility, and best results are to be expected. There is no way that an eye physician can competently check up on a refraction or skiascopy unless it is done over again by the physician.

"e. We do not hold that an optometrist is incompetent to refract and to do skiascopy, but rather, that legal restrictions, the lack of competent medical training in use and action of drugs on the eye, and the interpretation of drug action, necessary in many cases to do a correct and double-checked refraction and skiascopy, limit his sphere of activity.

"Therefore, we of this committee and under-

signed, recommend that the Passaic County Medical Society take action to prevent optometrists from doing refraction and skiascopy, even though "supervised" by an eye physician, in any hospital or clinic in Passaic County.

"Furthermore, we recommend that the Society act in this matter possibly through the Public Health Committee, or in any way deemed advisable, after due advice from counsel, to correct this problem in Passaic County.

"We further recommend the employment of one or more opticians or optometrists in eye clinics to make or order the making of eyeglasses and also to make all necessary adjustments of the finished eyeglasses to the patient."

(Signed) THOMAS M. GLASGOW

EDWARD EHRENFELD

JOHN S. VAN WINKLE

ELIAS J. MARSH

D. M. O'BRIAN

DAVID SHAPIRO

THOMAS A. SANFACON,
Chairman.

MILITARY SERVICE RELATIONS

Dr. J. Allen Yager then read the following report of the Committee on Military Service Relations, which was also adopted:

"In order that those who serve in the armed forces of the country may be properly protected during and after the emergency, the Committee on Military Service Relations of the Passaic County Medical Society makes the following recommendations:

"1. That as soon as a physician determines that he is to serve in one of the armed forces, arrangements be made with another practitioner to take care of his practice. The following plan is suggested to cover such arrangements:

"a. That the physician leaving his practice send a card (as below) to all his patients stating who is to be in charge of his practice during his absence and register such arrangement with the Passaic County Medical Society:

"Dr. A wishes to announce that because of the present emergency he is entering the military services of this country. During his absence his practice will be cared for by Dr. — (address and telephone number). Dr. A's records will be available, during his absence, to Dr. — at the request of his patients. Until his return it is suggested that Dr. A's patients will call Dr. — should illness make this necessary."

"b. That the locum tenens agree to the following arrangement: The money collected from patients who have been turned over to the locum tenens shall be placed in a separate fund. After deducting the amount necessary to cover overhead, the remaining fund shall be divided on a 50-50 basis; that when the practitioner shall return from military service, the locum tenens shall refer all of his patients back to him.

"Dr. — wishes to announce that Dr. A has returned from military service and will resume his practice."

"2. That all institutional, teaching and industrial appointments held by the practitioner at the time he enters military service shall be made available to him without loss of rights, seniority, or privileges when he returns from the service. Those individuals serving in such positions during the period of the emergency should feel that the acceptance of these vacancies is solely on a temporary basis.

"3. That a leave of absence be granted to all men called to active military duty so that they may return to Active Membership without the need of making a new application.

"4. That a pro rata share of the county portion of the annual dues be refunded to men called to military service. (Legal technicalities of its charter prohibit refund of State Society assessment.)

"5. That the leave of absence granted all men in active military duty shall in no way alter or influence their privilege in participation in the Physicians Relief Fund of the Passaic County Medical Society."

(Signed) G. E. TUERS, M.D., Chairman
V. F. DESMET, M.D.
MAX MAGNES, M.D.
A. MASUCCI, M.D.

THE MEDICAL SERVICE ADMINISTRATION

Dr. Thomas F. Lewis, President-Elect of the State Medical Society, was introduced and spoke briefly about the Medical Service Administration. He urged that every physician sign the Agreement. He also stressed the point that many military preparedness blanks had not been completed, and urged that those who need another blank contact the County Secretary.

DELEGATES TO THE ANNUAL MEETING

The following delegates and alternate delegates to the Annual Meeting of The Medical Society of New Jersey were elected:

Delegates:

A. A. Allen
Frank W. Ash
Thomas A. Clay
A. Hobson Davis
A. J. Delario
Armand De Rosa
Norman M. Dingman
William A. Dwyer
Wayne W. Hall
H. H. Hollingsworth
Sigurd W. Johnsen
Morris Joseph

James R. Lomauro
Allan W. MacGregor
Lester F. Meloney
David H. Mendelsohn
Joseph E. Mott
Charles J. Murn
William Spickers
L. E. Thron
Earl L. Warren
Hans Wassing
Harry Wolfson
J. Allen Yager

Alternate Delegates:

Joseph V. Bergen
Henry D. Bongiorno
Lawrence B. Boylan
Francis B. Brogan
John H. Carlisle
Homer H. Cherry
Edward Edlkraut
Theodore K. Graham
Joseph R. Jehl
Burton O. Kinney
John E. Leach
Herman Levy

John B. McDue
Alfred D. Meneve
Irving Okin
A. M. Schultz
Frederick Schwartzberg
Louis G. Shapiro
Carroll D. Smith
I. Jerome Sobel
John J. Szymanski
James J. Vanderbeck
Fred Vosburgh
William Weintraub

SCIENTIFIC

The speaker of the evening was Dr. George H. Hyslop, Attending Neurologist of Neurological Institute, whose topic was "Common Neurological Disorders Met with in General Practice". He gave an informal talk, stressing the various diagnostic theories in psychiatry today, and spoke of the changes which have taken place in the clinical picture of psychotic problems. There was discussion by Dr. Rothman and Dr. Wassing and other members.

SALEM COUNTY

By L. C. Hummel, M.D., Reporter

The monthly meeting of the *Salem County Medical Society* was held Friday, March 21, at the Tea Room, Salem, N. J.

ANNUAL SHAD DINNER

The date for our annual shad dinner was set for Wednesday, May 14. This is earlier than usual but was decided upon to prevent conflicting with the State Society meeting at Atlantic City.

SCIENTIFIC

The scientific session consisted of an address by Dr. Theodore Fetter, of Philadelphia, Pa. His topic was "The Management and Treatment of Prostatic Disease". The talk was well illustrated with slides and charts giving statistics and gross pathological specimens. He confined himself chiefly to the benign tumors and obstructions of the bladder neck and the different methods of treatment. He discussed transurethral resection, perineal prostatectomy and suprapubic prostatectomy. His address was very comprehensive and was enjoyed by all. A brisk discussion followed by several members of the society.

A dinner was served at the Tea Room following the meeting.

SUSSEX COUNTY

F. Herbert Lushear, M.D., Reporter

The regular meeting of the *Sussex County Medical Society* was held on February 25, 1941, at Sparta Inn, Sparta, New Jersey.

WELFARE COMMITTEE

Dr. Kirschner reported that the Welfare Committee had made an agreement with the Welfare Board, to be tried for six months, concerning medical fees for services to old age pensioners. All bills were to be sent to the head of an executive committee by the tenth of the month. A fee schedule was arranged for routine cases, and the committee was empowered to decide fees for extraordinary circumstances.

MEDICAL PREPAREDNESS COMMITTEE

It was reported that Dr. Scott is acting with Drs. Coleman and Pellet as examining physicians.

POST-GRADUATE EDUCATION COMMITTEE

Dr. Longnecker was instructed to draw up plans and make arrangements for a refresher course.

MEMBERSHIP COMMITTEE

Dr. Ewald H. Bergman and Dr. C. E. Spurgeon were received into the society. Dr. Loux's request for reinstatement was voted unanimously.

GENERAL BUSINESS

MEDICAL SERVICE ADMINISTRATION

Following a discussion of the new Medical Service Administration of New Jersey, the President and a member of his choosing were instructed to prepare a list of fifteen laymen to act with doctors of the Medical Advisory Council. The motion was passed unanimously.

NOMINATING COMMITTEE

Drs. Spencer, Spurgeon, and McCall were appointed on the Nominating Committee to name a slate of candidates for the May election.

BRITISH WAR AID

Following a discussion on British War Aid it was voted to receive donations toward an emergency kit, on which the name of the society will be placed as donor.

CONSTITUTION

It was voted that the proposed new Constitution, as prepared by Dr. Kirschner's committee, be submitted at the Annual Meeting in May.

The meeting adjourned at 1:30 a. m.

UNION COUNTY

C. C. Carpenter, M.D., Reporter

A regular meeting of the *Union County Medical Society* was held in the Elizabeth General Hospital, Elizabeth, on March 12, 1941, at 9 p. m., with the President, Dr. George Knauer, presiding.

SCIENTIFIC

Three Union County members gave a most interesting program on "Carcinoma of the Female Genital Organs", illustrated in detail with many unusual colored slides. Dr. Casilli, Elizabeth, discussed the pathology; Dr. Wuester, Elizabeth, gave the diagnosis and treatment; and Dr. Boyes, Plainfield, concluded with the Roentgen therapy.

MEDICAL SERVICE PLAN OF N. J.

Dr. N. M. Scott, Medical Director of the Medical Service Administration of New Jersey, reported that ten counties now qualify for operating insurance plans. He asked for more active cooperation by Union County members in the signing of the participating physicians' agreements. Union County is an important industrial section, and has several plants that are definitely interested in this insurance.

MEMBERSHIP

Seven applications for membership were received.

DUES OF MEMBERS IN MILITARY SERVICE

Dr. Lathrop proposed an amendment to the Constitution, that members of the County Society who

enter the military service be relieved of dues in the County Society.

ANNOUNCEMENTS

Dr. George G. Ornstein, Director of Metropolitan and Seaview Hospitals, New York City, will give the first lecture in the Refresher Course in Tuberculosis, on April 7 at 9 p. m., at the Elizabeth General Hospital, his topic being "The Modern Concept of the Division of Pulmonary Tuberculosis".

Dr. Casilli, Elizabeth, will give "Pathology and Pathogenesis of Tuberculosis Including Bacteriology" on April 8 at 10 a. m., New City Hall Chambers, Elizabeth.

This course is under the auspices of the Union County Medical Society, in cooperation with the Union County Tuberculosis League; and will continue from Monday, April 7, through Friday, April 11. The complete schedule of this week will be sent to each member of the Union County Medical Society.

The next meeting will be the Annual Meeting, and will be held in the Muhlenberg Hospital, Plainfield, April 9, 1941.

SUMMIT MEDICAL SOCIETY

E. H. Macpherson, M.D., Secretary

The regular monthly meeting of the *Summit Medical Society* was held at the Nurses' Home of Overlook Hospital on Tuesday evening, February 25th. Dr. David F. R. Steuart, the Vice-President, presided. There were twenty-eight members, and fifteen guests present.

Dr. R. MacBrayer of Ciba Pharmaceutical Products, was elected to membership to fill the vacancy caused by the death of the late Dr. Pollard, of Chatham.

Dr. E. R. Rickard of the Rockefeller Institute of New York gave a most instructive talk on "Epidemic Influenza". He had devoted seven years to the study of this subject, and was one of the workers who made the Virus Vaccine for Influenza. A which was given by the Summit Board of Health.

Following the meeting a collation was served.

The regular monthly meeting of the *Summit Medical Society* was held at the Nurses' Home of Overlook Hospital on Tuesday evening, March 24th. Dr. Johnston, the President, presided. There were twenty-three members and eleven guests present.

Dr. Johnston mentioned a joint meeting held on Tuesday afternoon in the Medical Library March 18th to pass resolutions following the death of Dr. Roger W. Moister in Arizona. It was agreed to attend the funeral in a body, at which twenty-three attended.

Dr. Prout discussed the sterilization bill now before the New Jersey State Legislature. He was strongly in favor of the passage.

Dr. Henry Falk, Clinical Professor of Gynecology of New York University, spoke on "Pathology and Management of the Septic Abortion". He outlined seven types and mentioned the treatment indicated in each. This was well illustrated by slides. An interesting discussion followed.

Following the meeting a collation was served.

WOMAN'S AUXILIARY

COMING EVENTS

ATLANTIC COUNTY

April 11, 1941, 9:00 p. m.
Hotel Ambassador, Atlantic City
Speaker: Mrs. Alan Rieck
Subject: Medical Histories and Their Compilation

CAMDEN COUNTY

May 8, 1941, 1:00 p. m.
Tairstock Country Club, Haddonfield, N. J.
Speaker: Mrs. A. Haines Lippincott
Subject: A dramatized reading
Guest: Mrs. R. J. McDonald
Installation of officers for 1941-42
Luncheon

ESSEX COUNTY

April 28, 1941, 2:00 p. m.
Academy of Medicine, Newark
Speaker: Herbert Thompson Strong
Subject: Exploring the Magic World of Color
Tea, honoring Doctors' Mothers

GLOUCESTER COUNTY

April 17, 1941, 9:00 p. m.
Woodbury Country Club
Business meeting

HUDSON COUNTY

May 5, 1941, 2:00 p. m.
Young Women's Christian Association, Jersey City
Installation of officers for 1941-42

MERCER COUNTY

April 28, 1941
New Jersey State Hospital, Trenton
Luncheon, Dr. Robert Stone, host
Dr. Stone will be one of the principal speakers

OCEAN COUNTY

May 2, 1941, 2:00 p. m.
Paul Kimball Hospital, Lakewood
Business meeting

PUBLIC RELATIONS MEETING

By MRS. E. REED HIRST, Publicity Chairman

The Public Relations Meeting of the Woman's Auxiliary to the Camden County Medical Society was held on Tuesday, March 25, with Mrs. L. L. Glover, President, presiding. There were 225 members and guests present. Visiting State Officers were Mrs. R. J. McDonald, Mrs. Don A. Epler and Mrs. Asher Yaguda.

Mrs. O. R. Carlander, Chairman of Public Relations, announced the program, the theme of which was "A Health Inventory".

The members and guests were greeted by Mrs. L. L. Glover, President of the Woman's Auxiliary to the Camden County Medical Society; Dr. Robert S. Gamon, President of the Camden County Medical Society; and Mrs. R. J. McDonald, President of the Woman's Auxiliary to The Medical Society of New Jersey.

The following addresses were presented:

Are You Allergic?—Harry L. Rogers, M.D., Allergist, Cooper Hospital

A Message of Hope—Mrs. A. Haines Lippincott, State Commander of the Woman's Field Army of the American Society for the Control of Cancer

Mental Hygiene of Childhood—Edward A. Strecker, M.D., Professor of Psychiatry, University of Pennsylvania School of Medicine; Chief of Service and Consultant, Institute of Pennsylvania Hospital

Medical Supervision of the Child—Vincent DelDuca, M.D., Pediatricist, Cooper Hospital; Member of the Academy of Pediatrics

Heart Disease as a Public Health Problem—Ralph K. Hollinshed, M.D., Physician and Cardiologist, Cooper Hospital

Dr. Rogers, in his address on allergy, pointed out that allergy is not a modern discovery. It dates back to 1815 when asthma was first discovered, and 1819, when hay fever was included. Drs. Alexon and Blackley were early pioneers in this field. Dr. Rogers differentiated between the term *allergy* and *idiosyncrasy*, the allergic manifestations being objective and the idiosyncrasies being subjective symptoms.

He stated that heredity is believed to be the most frequent cause of allergy, but there are both internal and external causes, and that untreated allergic conditions may last for years or may terminate spontaneously in cure.

Dr. Rogers named the common allergic diseases and the procedure by which they are recognized. He mentioned the limited effect of drugs and climate, and stressed the fact that the diseases can in most cases be cured after careful study.

Dr. Strecker in his address on "Mental Hygiene of Childhood" urged against undue stress

on childhood and suggested that children be regarded by parents as a normal part of life, and that normal physical, mental and emotional environments are essential to the child's proper growth and development.

He stated that personality is the result of the emotional environment and is a very complex and intangible subject. He discussed his conception of growth and development and environmental influences. He urged sufficient freedom being given the child to learn from his environment and how to adjust himself to it through the natural instincts of love of power, curiosity, imitation and motion. The child is extremely susceptible to suggestion, and out of our accumulated experiences we are to use these tools in leading our children sanely and helping them become the individuals we wish them to be.

Dr. DelDuca spoke on the physical care of the child beginning before he is born, through proper attention to the care of the parents.

Half of the deaths which occur in the first year of life occur during the first month. He mentioned the importance of vitamins in the deficiency diseases and stressed the necessity for early provision of cod-liver oil and orange juice to supply any deficiency; urged protection through immunizations; and stressed the marked effect of the nervous system on the appetite and digestion.

Dr. Hollinshead spoke on "Heart Disease as a Public Health Problem". He pointed out the conditions which lead to heart disease and emphasized that the cause of these conditions, with the single exception of syphilis, is as yet unknown; and that the syphilitic type could be helped, or even cured, by early treatment, and could be prevented entirely.

The solution of rheumatic heart disease lies in the hope of discovering the way to eliminate it from children and young adults. The arteries, he mentioned, still indicate the physical age of the patient.

THE BULLETIN

Every Auxiliary member must be aware that one of the foremost aims of the National Board this year is to have every member be a subscriber to the *Bulletin*. The chief difficulty in this campaign has been the matter of convincing the membership that subscription to the *Bulletin* is not only profitable to the work and activities of the Auxiliary, but indispensable to the individual member who is desirous of keeping informed, and active, in the accomplishment of our objectives as an organization. We may well regard the circulation of the *Bulletin* as a barometer of the spirit and enthusiasm prevailing in our organization.

What may the reader reasonably expect in the way of benefits from the pages of the *Bulletin*? These benefits might be listed as follows:

- Information.
- Inspiration.
- Activity.
- Coöperation.
- Accomplishment.
- New conception of service.

An informed membership is the first requisite for ordered and intelligent activity. An informed member would come to the meetings with something to contribute, rather than in the hope that something she hears may be of interest. Without information there can be no inspiration worthy of the name. The *Bulletin* is now a source of inspiration to those of our membership who subscribe to it. A result of inspiration is activity. When a member sees that an organization is really going somewhere, she will pitch in and do her part with more spirit and enthusiasm than she would give to a seemingly stagnant cause. Accomplishment begets accomplishment. With the successful completion of each endeavor comes a desire to press on to further successes. The reading of the *Bulletin* gives the members an inclusive panorama of achievement and progress that stimulates new conceptions of service. It serves to make each new success a stepping stone to additional successes. That is true progress.

Subscribe to the *Bulletin*.

REPORT OF THE NOMINATION COMMITTEE

President-Elect	Mrs. J. Howard Hornberger, Florence
First Vice-President	Mrs. Alvah Bickner, Rutherford
Second Vice-President	Mrs. W. D. Miningham, Newark
Secretary	Mrs. Banks Baker, Camden
Treasurer	Mrs. Thomas P. McConaghy, Camden
Directors for three years	Mrs. David B. Allman, Atlantic City Mrs. R. J. Faulkingham, New Brunswick

Respectfully submitted,

MRS. GERALD E. McDONNEL, Chairman
MRS. CHESTER I. ULMER
MRS. JOHN S. MADARAS
MRS. HOWARD N. MEYER
MRS. JAMES MASON

WOMAN'S AUXILIARY TO A. M. A.

Only a few weeks more and the members of the Woman's Auxiliary to the American Medical Association will be arriving in Cleveland for their Annual Convention, June 2-6. Have you made your

reservations? If not, send your request, at once, to Dr. Edward F. Kieger, Chairman of the Committee on Hotels and Housing, 1604 Terminal Tower Building, Cleveland, Ohio.

COUNTY AUXILIARIES

Atlantic County

Reported by Mrs. Matthew Molitch, Press and Publicity Chairman

The regular meeting of the *Woman's Auxiliary to the Atlantic County Medical Society* was held on Friday, March 14, 1941, with Mrs. Anthony G. Merendino, President, presiding, and twenty-one members present.

Mrs. Carl Surran, Program Chairman, stated that a musical program has been arranged for the Reciprocity Tea which the Auxiliary gives with the Women's Club of Atlantic City. Dr. Samuel Salasin will speak on the subject "Diet".

The program for the next meeting of the Auxiliary will be in the care of Mrs. Alan Rieck, Chairman of Art, Hobby and Medical History. Mrs. Rieck has completed six medical biographies this year.

The program for the day was a talk by Dr. Carl Surran on "Medical Legislation and Why". The Legislative Chairman was in charge of the program, and she read an article from the State Chairman of Legislation explaining various bills that are before the legislators concerning medical legislation. Mrs. Stamps then read a letter from Dr. David B. Allman, Legislative Chairman of the Atlantic County Medical Society, bringing to our attention four Assembly bills and one Senate bill on medical legislation.

Bergen County

Mrs. J. W. Demarest, Chairman of Publicity

The regular meeting of the *Woman's Auxiliary to the Bergen County Medical Society* was held March 12 with Mrs. Raynold Berke presiding. There were twelve members present. The meeting was held at Holy Name Hospital, Teaneck.

Miss Marie Wooders, Director of Nurses at Hackensack Hospital, was the speaker. Miss Wooders' subject was "Modern Nursing in Conjunction with National Defense". Refreshments were served.

Camden County

Mrs. E. R. Hirst, Publicity Chairman

The regular meeting of the *Woman's Auxiliary to the Camden County Medical Society* was held at 2:00 p.m. on Tuesday afternoon, March 4, in the home of Mrs. Oram R. Kline, in Woodbury, N. J. Mrs. Lawrence L. Glover, President, presided, and thirty-eight members were present.

Mrs. O. W. Saunders, Hospitality Chairman, announced that the Tavistock Country Club has been reserved for the Annual Luncheon, to be held on May 8, 1941.

Mrs. A. H. Lippincott, Legislative Chairman, read the platform of the American Medical Association; and also urged all members to assist in cancer control.

The Greek relief work was reported as rapidly progressing. Several members of the Auxiliary have given the card parties and luncheons as benefits, and other groups are responding willingly.

Mrs. H. F. Bushey, membership chairman, proposed six new members:

Mrs. H. F. Johnson, Collingswood, N. J.
Mrs. J. P. Rudolph, Merchantville, N. J.
Mrs. J. R. Eynon, Collingswood, N. J.
Mrs. W. T. Snagg, Camden, N. J.

Absent:

Mrs. M. H. Gordon, Camden, N. J.
Mrs. E. Sufrin, Camden, N. J.

The Annual Public Relations meeting, Mrs. O. W. Saunders, chairman, will be held on March 25, in the Camden Woman's Club, 424-26 Linden Street. This will be an all-day session, with interesting speakers for the morning and afternoon.

The resignations of Mrs. Oram R. Kline, as President-Elect, and Mrs. M. L. Weimann, as Director 1941-1943, were accepted with regret.

New officers elected are:

President, Mrs. George B. German
President-Elect, Mrs. A. L. Stone
First Vice-President, Mrs. Henry R. Tatem, Jr.
Second Vice-President, Mrs. M. L. Weimann
Third Vice-President, Mrs. William J. Scruggs
Treasurer, Mrs. Lester R. Wilson
Recording Secretary, Mrs. A. G. Pratt
Corresponding Secretary, Mrs. A. G. Kinney
Directors (three years): Mrs. L. L. Glover,
Mrs. Oram R. Kline

The installation of these officers will take place at the annual luncheon of the organization, to be held at the Tavistock Club, May 8.

Mrs. R. S. Gamon, Program Chairman, announced that two new books had been chosen for review, by two members of the Auxiliary:

"The Fire and the Wood" by R. C. Hutchinson,
reviewed by Mrs. A. G. Pratt;
"As I Remember Him" by Hans Zinsser, reviewed by Mrs. M. L. Weimann.

Essex County

Reported by Mrs. Frank S. Forte, Chairman of Publicity

The *Woman's Auxiliary to the Essex County Medical Society* held its regular monthly meeting on Monday, February 24th, at the Academy of

Medicine, Newark, N. J., with Mrs. J. Irving Fort, President, presiding.

The members voted to give the British Relief one hundred and fifty dollars.

Mrs. William Donahue, Public Relations Chairman, announced that Health Institute Day would be held on March 24 at the Academy of Medicine, 91 Lincoln Park. Invitations will be sent to several organizations.

The third Annual Dance given by the Auxiliary will be held on April 23rd, at the Crestmont Country Club. Mrs. Joseph Clarkin is chairman, assisted by Mrs. Jesse Glazier.

A moving picture illustrating the weaving and making of textiles, together with a travelogue, was shown by the New Jersey Laundry Owners' Association. Mrs. Stuart Hawkes, Program Chairman, introduced the speaker, Mr. Harold C. Buckelew, who represented the Association.

During the meeting the members sewed for the Red Cross. Tea was served at the close of the meeting. Mrs. Joseph Echikson and Mrs. Frank S. Forte poured.

Gloucester County

By Mrs. C. A. Bowersox, Public Relations Chairman

The regular meeting of the *Woman's Auxiliary to the Gloucester County Medical Society* was held on Thursday, February 20, at 9 p.m., with the President, Mrs. Paul M. Pegau, presiding. There were nine members present.

The March meeting was held Thursday evening, March 20, at 9 p.m., with the President, Mrs. Paul M. Pegau, presiding. There were eighteen members present and one Camden County Auxiliary guest.

Reports were received from the Program Committee on the Reciprocity Tea to be held in April.

Mrs. Oram R. Kline, of Woodbury, gave an outline on Cancer Control and urged all members to work for this cause.

The meeting was followed by a white elephant party.

Hudson County

Reported by Mrs. Sydney Chayes, Publicity Chairman

The *Woman's Auxiliary to the Hudson County Medical Society* met in the parlors of the Young Women's Christian Association, Fairmont avenue, Jersey City, N. J., on March 3, 1941. This was a Reciprocity and Public Health meeting, and many women's organizations throughout Hudson County were represented. Mrs. Arthur Largay, President, greeted the guests, and turned the meeting over to Mrs. Abraham Ruoff, chairman of the afternoon, who introduced the speakers. Dr. George Kerdasha,

of Union City, spoke on "Preventable Diseases" and Dr. Julius Hellbrunn, of Jersey City, discussed Child Psychology.

Mrs. Don A. Epler, of Newark, was introduced and she made a short address urging the members to attend the State Meeting at Essex House, Newark, March 10.

Plans were announced for a theatre party March 31 in New York City, the play to be "My Sister Eileen".

Mrs. Samuel Scott read a letter from Mr. C. G. Padel, General Secretary of the National British War Relief Society, New York City, thanking the Auxiliary for the gift of a Mobile Kitchen to be sent to England. The kitchen was exhibited at Journal Square, Jersey City, February 24, 25, and 26. Kitchens at present are more timely than ambulances, as casualties are fewer than the British Government expected, and the homeless are more numerous. They are staffed by Americans and go about feeding the homeless in the bomb-wrecked areas.

Following the meeting tea was served.

Passaic County

Mrs. J. E. Mott, Chairman of Press and Publicity

The regular business meeting of the *Woman's Auxiliary to the Passaic County Medical Society* was held on March 17th, at the home of Dr. and Mrs. A. Kovin at Passaic, N. J., with Mrs. Alfred D. Meneve presiding. Reports were given by committee chairmen:

Mrs. Harry Dawson, Legislation

Mrs. J. S. Gallo, Membership

Mrs. J. E. Mott, Press and Publicity

Mrs. C. B. Russell, Art and Hobby

Mrs. A. E. McBride, Widows and Orphans

Mrs. Leslie Taber, State Bulletin.

Mrs. Joseph R. Jehl, general chairman of the Supper-Dance to be held in honor of Doctor's Day on March 29th, announced that all plans are complete and that Mrs. Richard J. McDonald, State President, has been selected as Honorary Chairlady.

Mrs. Charles B. Russell, Program Chairman, introduced Miss Viola Bears, who gave several excellent book reviews. Tea was poured by the hostess while musical selections were rendered by guests.

On April 21 the Woman's Auxiliary to the Passaic County Medical Society will conduct a "Health Forum" open to the general public. There will be medical and scientific exhibits including oxygen tents, diathermy apparatus, motion pictures on pneumonia entitled "Sniffles and Snuffles".

Dr. Norman M. Scott, Medical Director of Medical Service Administration of New Jersey, will speak on "Problems Involved in the Distribution of Medical Care".

BOOKS RECEIVED FOR REVIEW

Books reviewed in these columns may be seen at the library of the Academy of Medicine.

Clinical Pellagra. By Seale Harris, M.D., assisted by Seale Harris, Jr., M.D., with foreword by E. V. McCollum, Ph. D., Sc. D., L.L.D. Pp. 494. St. Louis, C. V. Mosby Co. 1941. \$7.00.

Plague On Us. By Geddes Smith. Pp. 365. New York, Commonwealth Fund. 1941. \$3.00.

Electrocardiography in Practice. By Ashton Graybiel, M.D., and Paul D. White, M.D. Pp. 319 with 272 illus. Philadelphia, W. B. Saunders. 1941. \$6.00.

Diseases of the Digestive System. Ed. by Sidney A. Portis. Pp. 952. Philadelphia, Lea & Febiger. 1941. \$10.00.

Anus, Rectum and Sigmoid Colon. By Harry Elliott Bacon. 2d ed. Pp. 857 with 507 illus. Philadelphia, J. B. Lippincott Co. 1941. \$8.50.

Macleod's Physiology in Modern Medicine. Ed. by Philip Bard, M.D. 9th ed. Pp. 1256. St. Louis, C. V. Mosby Co. 1941. \$10.00.

Introductoin to Dermatology. By Richard L. Sutton and Richard L. Sutton, Jr. 4th ed. Pp. 904. St. Louis, C. V. Mosby Co. 1941. \$9.00.

Manual of Physical Diagnosis, with Special Consideration of the Heart and Lungs. By Maurice Lewison and Ellis B. Freilich in collaboration with George C. Coe. Pp. 317. Chicago, Yearbook Publishers. 1941.

BOOK REVIEWS

MANUAL OF CLINICAL CHEMISTRY. By Miriam Reiner, M.Sc., Assistant Chemist to the Mount Sinai Hospital, New York. Introduction by Harry Sobotka, Ph.D., Chemist to the Mount Sinai Hospital, New York. With 18 illustrations. Interscience Publishers, Inc., New York, 1941.

This is a remarkably concise, lucid, and valuable manual. Almost anyone could follow the instructions. Its value is greatly enhanced by the inclusion of the sources from which the tests have been taken, and also by the fact that the author has described those tests which have proved to be the best over a period of time in a large and active laboratory. Omissions can be discovered, of course, and there is no mention of the procedure for sulfanilamide and its derivatives in the stool.

This little book is highly recommended.

C. A. BELING, M.D.

MEDICAL NURSING. By Edgar Hull, M.D.; Christine Wright, R.N., B.S., and Ann B. Eyle, B.S. Pp. 588. Philadelphia, F. A. Davis Co. 1940. \$3.50.

A physician, a dietitian and a nurse have collaborated in this text of medical nursing. The result is a splendid correlation of general medicine, nursing care, and diet therapy. The authors have succeeded in their aim "To impart to the student nurse an understanding of the principles of general medicine, to furnish her brief, yet accurate, descriptions of important diseases which fall within the realm of internal medicine, and to indicate the medical treatment, nursing care, and dietary management of these diseases."

The educational function of the nurse might have been stressed more. Under the discussion of syphilis, no mention is made of the nurse's part in the nation-wide campaign for eradication of syphilis.

The material is presented in a clear, well-organized and interesting manner. The pages are printed with two columns to a page, which is conducive to

rapid reading. Information is up-to-date. Many illustrations are given.

B. M. McKEE, R.N., Instructor
Presbyterian Hospital, Newark.

ANUS, RECTUM AND SIGMOID COLON, DIAGNOSIS AND TREATMENT. By Harry Ellicott Bacon. 2d ed. Pp. 857 with 507 illus. Philadelphia, J. B. Lippincott Co. 1941. \$8.50.

This is an excellent contribution to the field of the anus and rectum. A specialist in proctology describes concisely and with many clear-cut illustration, disorders in these parts which a general practitioner would like to know. How to recognize and treat fissures, fistula, pruritis ani, hemorrhoids, cryptitis, to mention only a few. For the general surgeon he offers, besides his own, various operative procedures by specialists in this field, on such a variety of conditions as anesthesia, congenital malformations, the common ano rectal lesions, prolapse, procidentia and benign and malignant lesions. The latter, in its various phases, alone covers over one hundred pages. For those who specialize in proctology he has contributed a book useful for teaching purposes.

This second edition is a much more pretentious work than the first edition published in 1938. New material has been added, particularly operative procedures. Chemotherapy is discussed as it applies to ulcerative colitis and lymphogranuloma venereum. Recent investigations in various fields of proctology have been included.

This reviewer was impressed not only by the excellent illustrations, the multiplicity of operative procedures, but also by the complete bibliographies at the end of each disease discussed which are a useful introduction to the literature in each field.

For those desiring an outstanding volume on proctology this book is highly recommended.

J. GERENDASY, M.D.

A CORRECTION

The Virus: Life's Enemy. By Kenneth M. Smith. Listed in the review in the Journal, February, 1941,

page 106, as Oxford University Press. Should have been Cambridge University Press.

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TO THE MEMBERS OF THE MEDICAL SOCIETY OF NEW JERSEY

PLACE	NAME AND ADDRESS	TELEPHONE
AUDUBON	W. H. Tegler, 315 Atlantic Ave.	Audubon 1037
BAYONNE	Nelson Dittmar, Ph. G., 924 Broadway at 44th St.	BAYonne 3-0406
BELMAR	William T. Lins, 1500 F St., cor. 15th Ave.	Belmar 559
BERNARDSVILLE ...	Hemmendinger Pharmacy, 12 Mine Brook Rd.	Bernardsville 78
BLOOMFIELD	Nicholas G. Burgess, 50 Broad St.	Bloomfield 2-1006
COLLINGSWOOD	Oliver G. Billings, 760 Haddon Ave.	Collingswood 4034
CRANFORD	J. Walter Seager, 103 Union Ave. N.	CRanford 6-0700
ELIZABETH	Kerner's Prescription Pharmacy, 504 Court St.	ELizabeth 3-9497
HACKENSACK	Gorman-Noble Drug Co., 269 Main St.	HACKensack 2-0660
HARRISON	Squier's Pharmacy, 234 Harrison Ave.	Harrison 6-2127
JERSEY CITY	Smith & Williams Prescription Phar., 343 Jackson Ave.	BERgen 3-2616
MONTCLAIR	Wm. J. McNulty, So. Fullerton Ave. & The Crescent.	MONTclair 2-2014
MORRISTOWN	Carrell's Pharmacy, Inc., 31 South St.	MORristown 4-0143
NEWARK	Marquier's Pharmacy, Sanford & So. Orange Aves.	ESsex 3-7721
NEWARK	Rosenbluth's Pharmacy, 109 Springfield Ave.	MARKet 3-1509
NEW BRUNSWICK ...	Hoagland's Drug Store, 365 George St.	New Brunswick 49
PLAINFIELD	The Richmond Pharmacy, 209 Richmond St.	PLAINfield 6-5312
RED BANK	The H. T. Young Pharmacy, 85 Broad St.	Red Bank 164
RUTHERFORD	Bergen Pharmacal Co., Park & Erle Aves.	RUTherford 2-0034
SOUTH ORANGE	Taft's Pharmacy, 2 So. Orange Ave.	SOUTH Orange 2-0063
TRENTON	Stover's Pharmacy, Inc., Broad and Market Sts.	Trenton 5030
UNION	Union Center Pharmacy, 1015 Stuyvesant Ave.	UNIonville 2-0876
WEST NEW YORK ...	The Owl Pharmacy, 6611 Bergenline Ave.	UNIon 5-0384

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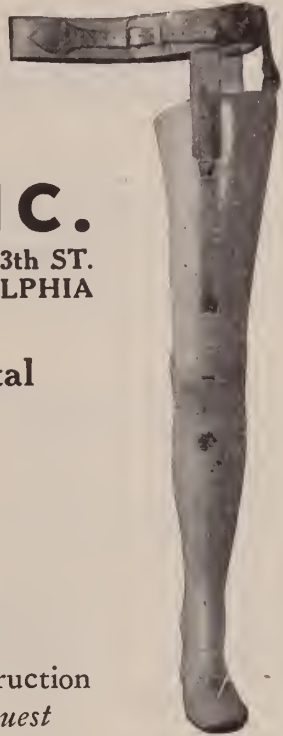
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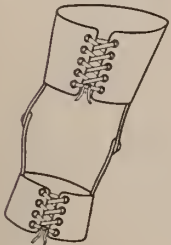
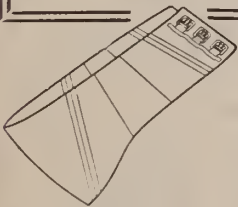
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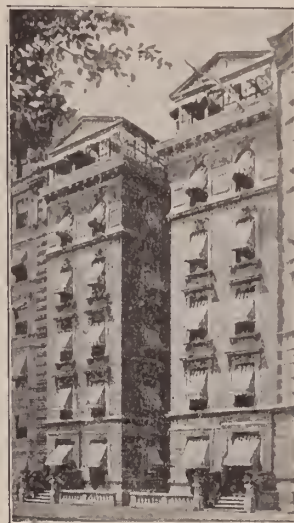
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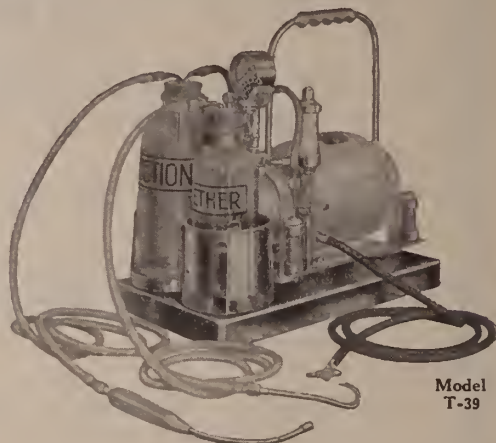
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Eye, Ear, Nose and Throat

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State House, Trenton, N. J.
Tel. 2-2131, Ext. 541

State Crippled Children's Commission

J. G. BUCH, *Chairman and Director*
732 Broad Street Bank Building, Trenton
Tel. 2-2131, Ext. 785

State Board of Children's Guardians

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163 West Hanover Street, Trenton
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Room 1101, Tel. Trenton 2-2131, Ext. 272

New Jersey Health Officers' Association

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Thomson Hall, Princeton, N. J.
Tel. Princeton 1005

New Jersey Health and Sanitary Association

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Freehold, N. J.
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Department of Institutions and Agencies

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New Jersey State Nurses' Association

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Tel. Bergen 3-7000

New Jersey Hospital Association

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Department of Motor Vehicles

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State House Office Building, Trenton
Tel. 2-2131, Ext. 208

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Meetings at the call of the Chairmen

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DAVID B. ALLMAN (1944)Atlantic City
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GEORGE J. YOUNG, *Ex-Officio*Morristown

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LANCELOT ELY (1941)Somerville
E. ZEH HAWKES (1943)Newark

Medical Defense and Insurance

CHRISTOPHER C. BELING, *Chairman* (1943)Newark
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WILLIAM WESCOTT (1941)Atlantic City
CHARLES F. BAKER (1942)Newark
CHARLES J. LARKEY (1943)Bayonne
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Publication

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EDWARD J. ILL (1943)Newark
J. LAWRENCE EVANS (1941)North Bergen
WATSON B. MORRIS, *Ex-Officio*Springfield
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ILY R. BEIR (1943)Atlantic City
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WILLIAM J. CARRINGTON (1942)Atlantic City
CLARENCE L. ANDREWS (1941)Atlantic City
WILLIAM W. HERSOHN (1943)Atlantic City
THOMAS MCG. BRENNOCK (1941)Jersey City

Scientific Program

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MARTIN H. COLLIER	Grenloch
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HENRY H. KESSLER, <i>Technical Adviser</i> , representing Department of Labor	Newark

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DAVID W. GREEN, <i>Consultant</i>	Salem
DANIEL BERGSMAN, <i>Technical Adviser</i> , representing Depart- ment of Health	Trenton

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ARTURO R. CASILLI, <i>Vice-Chairman</i>	Elizabeth
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WALTER A. TAYLOR	Trenton
JEROME H. SAMUEL	Newark
W. JAMES MARQUIS	Newark
ASHER YAGUDA	Newark
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Contract Practice

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HARVEY T. HEROLD, <i>Vice-Chairman</i>	Newark
HENRY HAYWOOD	New Brunswick
EDWARD F. KLEIN	Perth Amboy
J. HOWARD HORNBERGER, <i>Consultant</i>	Roebling

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CHARLES HYMAN	Atlantic City
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Industrial Health and Hygiene

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Medical Care of the Indigent and Low-Wage Group

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WILBUR WATTS	Trenton
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HUDSON	John J. McCarthy	616 35th St., North Bergen	Palisades 6-2385
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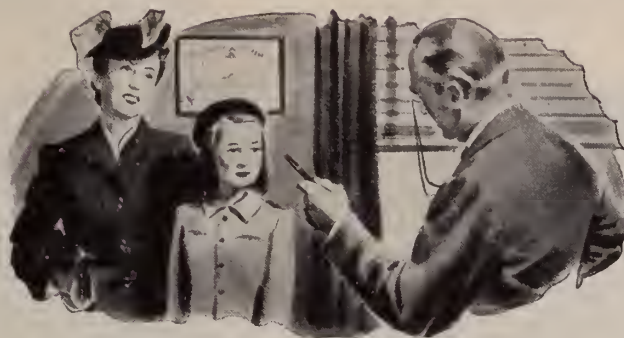
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1939. Accepted Foods and Their Nutritional Significance, Council on Foods of the American Medical Association, Chicago.

1939. Food and Life: Yearbook of Agriculture. U. S. Dept. of Agriculture, U. S. Government Printing Office, Washington, D. C.

1939. Canned Food Reference Manual, American Can Company, New York.

1938. Nutrition Abstracts and Reviews 8, 281.



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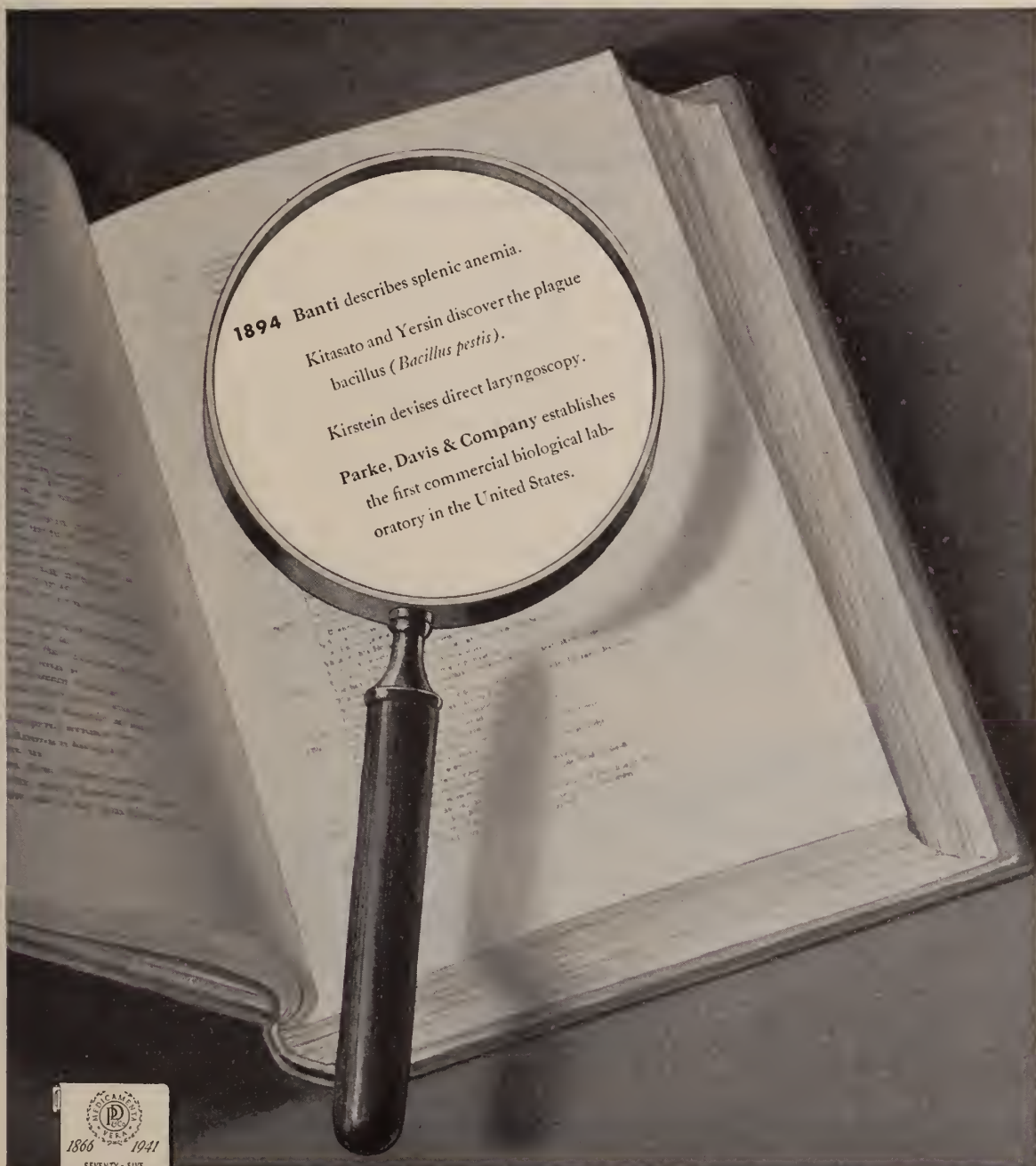
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Hypothetical Combinations	Geyser Water	Hathorn Water	Coesa Water
Ammon. chlorid	48.25	59.10	33.30
Lithium chlorid	21.07	64.49	46.43
Potass. chlorid	361.91	789.54	714.86
Sodium chlorid	2,010.48	8,594.84	4,233.14
Potass. bromid	9.23	160.00	13.90
Potass. iodid	1.10	4.80	1.36
Sodium sulphate	None	None	None
Sod. metaborate	Trace	None	Trace
Sodium nitrate	Trace	Trace	Trace
Sodium nitrite	Trace	Trace	Trace
Sodium bicarb.	2,213.78	424.71	1,331.15
Calcium bicarb.	1,829.14	3,380.84	2,519.74
Barium bicarb.	16.67	25.65	25.00
Strontium bicarb.	Trace	Trace	Trace
Ferrous bicarb.	9.94	40.07	5.86
Magnes. bicarb.	753.89	2,244.88	1,186.57
Alumina	7.14	4.98	6.37
Silica	19.49	14.40	12.80
Total	7,284.00	15,808.30	10,130.48

Look for the Seal of The State of New York on every bottle of the genuine waters of Saratoga Spa.



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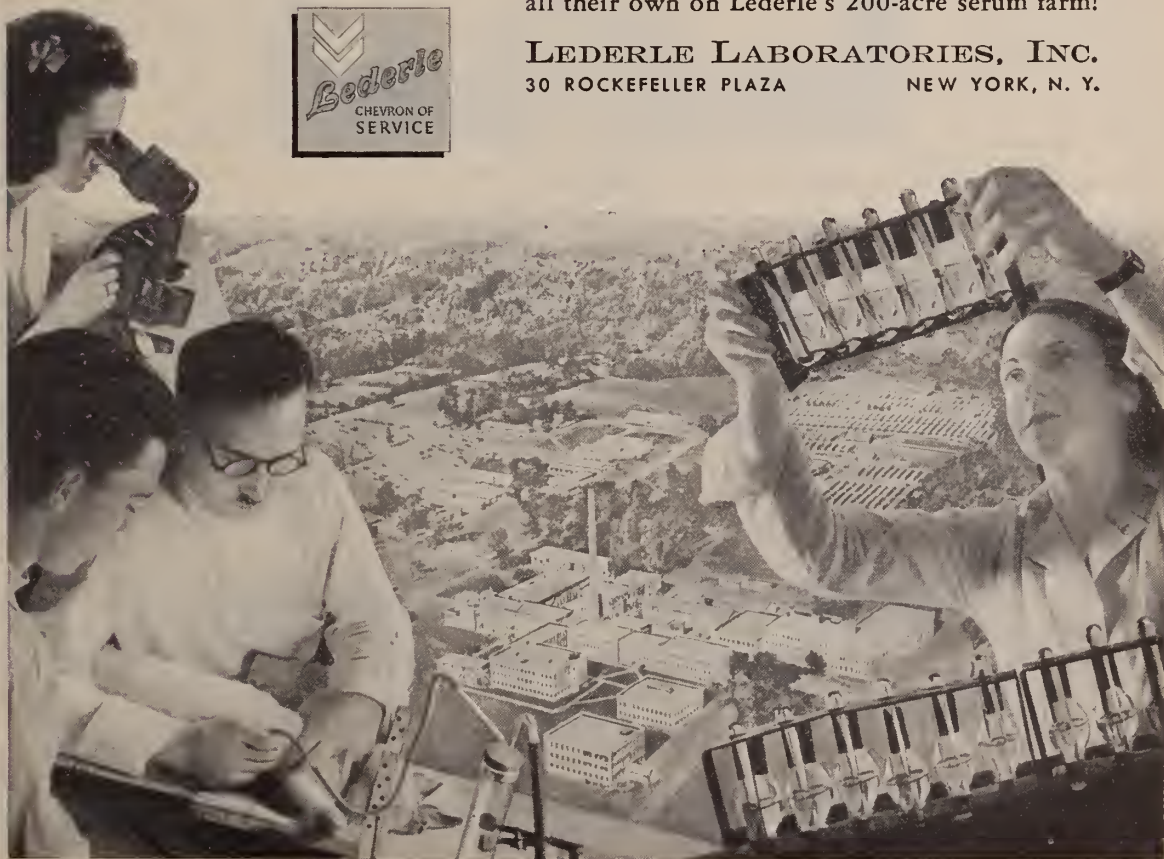
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Despite the elaborate treatment necessary to produce Walker-Gordon Homogenized Soft Curd Milk, *the price of this milk is the same as the price of the untreated Walker-Gordon Certified Vitamin D.*

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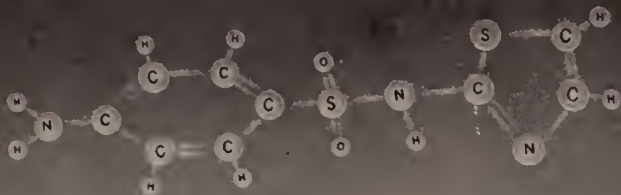
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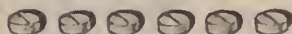
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* Division of Medicinal Chemistry, American Chemical Society, April 6, 1939, P. J. Fatsbinder and L. A. Walter.

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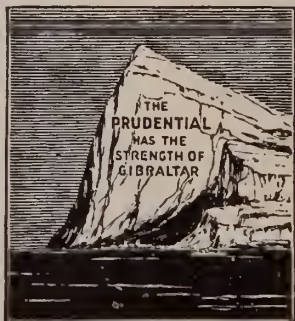
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Kugelmass: "Newer Nutrition in Pediatric Practice."
J. B. Lippincott Co., Philadelphia, 1940, p. 334.

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Ariyama & Takahasi, Biochemische, Zeitschrift, vol. 216, p. 269, 1929.

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Marriott: "Infant Nutrition."
C. V. Mosby Co., St. Louis, 1930, p. 45.

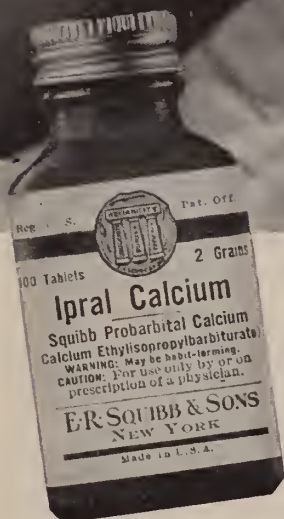


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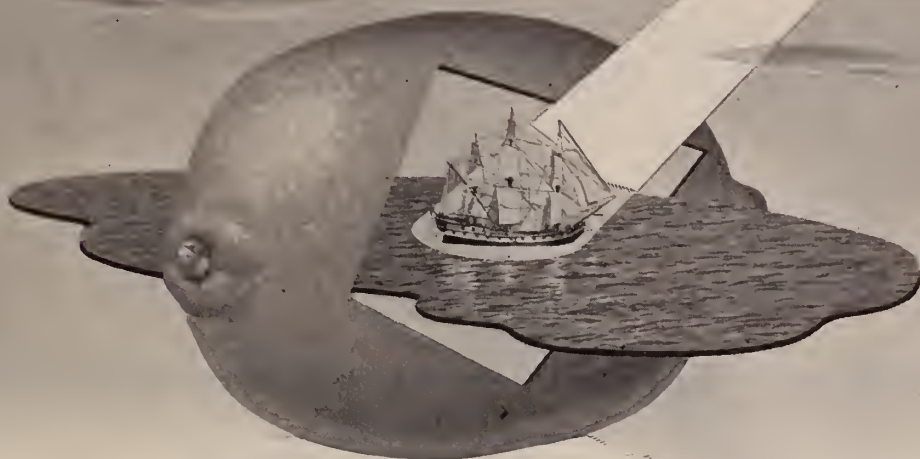


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The Victory Over Scurvy



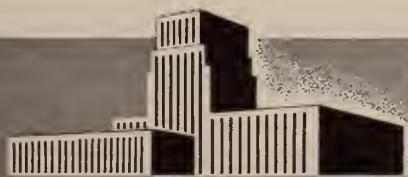
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THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

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THE MEDICAL SOCIETY OF NEW JERSEY ANNUAL REPORTS TO THE HOUSE OF DELEGATES

May 20-22, 1941

REPORT OF THE PRESIDENT

By WATSON B. MORRIS, M.D., Springfield, N. J.

To the House of Delegates:

Another year in the history of the Medical Society is about to close. At this time the suggestions and policies as outlined in the beginning of the present Administration may well be evaluated by "taking an account of stock".

The Annual Reports of the last few years are interesting reading, and contain much valuable information as to the several activities which have been carried on from year to year, and what has been accomplished.

During the past year The Medical Society of New Jersey has continued many of the projects set forth in these reports, and added some new ones.

Some of the suggestions outlined in my Inaugural Address were among the more important ones that needed our attention.

MEDICAL PREPAREDNESS

Soon after the close of the Annual Meeting we were called upon to follow out the suggestions for Medical Preparedness outlined by the Federal Government and the American Medical Association. It is gratifying to record the prompt response of the members of the County Societies in this undertaking. Both the State and County Medical Preparedness Committees have worked hard and long in carrying out the Federal program, and through the splendid coöperation of our individual members, New Jersey stands well ahead of most of the other states in this endeavor.

MEDICAL SERVICE ADMINISTRATION

Another activity of the Society which has had precedence over others is that of the Medical Service Administration. This proposed study had its inception in 1938 and has met many difficult problems, but through the constant and continuous study of the Voluntary Health Insurance Committee the plans evolved now stand ready to meet the needs for which the study was made. This project deserves the support of every member of the Society if we

are to control the practice of medicine. If it succeeds we can have a plan with which to meet any Federal legislation which might be proposed. If we fail, we will have no logical argument or redress against others who try.

Our Legislators have given us authority to direct the distribution of medical care, and we must justify the faith placed in us by proposing to them that we have both the ability and the will to carry it out. The Medical Service Administration is your organization, administered under the supervision and control of our own members, so should receive the wholehearted support and coöperation by every member of the Society who prefers to practice in the American Way, rather than under Federal or lay agencies.

VISITING COUNTY SOCIETIES

Your Officers have already visited most of the Counties, and before the close of the year plan to complete the list, either attending an official meeting or a social gathering. It has been quite noticeable that most of the Societies are better organized and do better "team work", and that each year more is accomplished within a given time, with greater economy.

All of the Committees have been active and have accomplished and recorded much in their reports.

PUBLIC RELATIONS

As in former years, our relations with the public have been stressed in an effort to keep the people informed as to what the profession is trying to do to meet the demands placed upon them. Through exhibits, the press and the speakers' bureau we are spreading the philosophy of the profession to health workers and lay groups and have met with signal success.

The improved mutual relations existing between the allied professions and the Medical Society have been an outstanding feature of the year, and should not only be continued, but

should be expanded in all possible directions. We need their coöperation and they welcome ours.

LEGISLATION

Our legislative interests have been well guarded, and again we see the need of such an active Committee in the Society. At present the Uniform Medical Practice Act is under fire. A repealer has been introduced, and although it is being carefully watched the support of every member of the Society is necessary if this splendid law is to survive the onslaughts of those who would destroy it.

We need not only the "keymen" in every County, but also the help of every individual doctor to make the necessary personal contacts with our Legislators, and if this is done we need not fear the outcome.

There has been a definite advance in the problem of amendments to the Compensation Law. Legislation has been introduced which, if passed, will be of decided advantage to the profession.

RELATIONS TO SPECIALTIES

The Maternal Welfare Committee's report speaks for the efforts and efficiency of those entrusted with this responsibility, and their record may well be the envy of any other State in the Union.

The strides made in this State through the promotion of mass tuberculosis testing for "early diagnosis", both in the schools and in the Induction Boards, is worthy of the favorable comment which it has received, not only by experts in our own State but by officers of the National Tuberculosis Association.

The cancer problem has received much careful thought and consideration. If we are to know how many such cases exist, and the final results of treatment, this should be made a reportable disease. This suggestion has been made to the State Board of Health and should have the support of the members.

The various Advisory Committees to the Sub-Committee on Medical Practice have been very active this past year. Material has been assembled for a new issue of the Formulary which will be widely distributed among the Resident and Intern Physicians throughout the State.

The Advisory Committee on Industrial Health and Hygiene is progressing favorably. Many individuals and organizations have been consulted in an effort to meet the needs of those most vitally concerned, and of National Defense.

Our indigent sick have had careful consideration during the past year due to a change

in the administration. The plan outlined in 1939 has been adopted. It will follow the general ideas contained in the Old Emergency Relief medical plan, but will remain optional with the various municipalities unless some further legislation is enacted.

The question of mass Wassermann testing in industry has received much consideration due to the fact that many outside agencies have already obtained or are planning to take Wassermanns on industrial employees throughout the State and use physicians employed and paid by the government. It should be approved if done by or under the supervision of a fully licensed local physician or by one appointed by the industry in that community.

POST-GRADUATE EDUCATION

Post-graduate education is receiving more and more attention not only in our own State but throughout the entire country. There has been formed a permanent organization known as the Associated State Post-Graduate Committee of the State Medical Societies. This group is aware of the fact that medical practice is under fire and is being carefully studied by lay agencies with the hope that they can prove that under the present plans the public does not receive adequate medical care and that the government should take over the control in order to provide that care.

This nation-wide group, realizing these facts, is planning to help keep the profession informed on providing the best of medical services—not only as a service, but also in the interests of public health.

ANNUAL CLINICAL CONFERENCE

The Annual Clinical Conference, which met in Newark this year, was a huge success. The clinics were carefully planned to meet the needs of the general practitioner and were well attended. The lectures at the City Hospital and at the Academy of Medicine drew a capacity crowd as did the "get together" dinner on the evening of the first day of the session.

RECOMMENDATIONS

After attending meetings of practically all of the State Society committees and making a survey of their activities throughout the State, I am impressed with the real sincerity of most of the members and wish to make the following recommendations:

1. That the Medical Service Administration be supported throughout its experimental period of one year with the hope that it not only will succeed but will prove a challenge to any form of State or Federal controlled Medicine—and meet the needs of the low-wage group.

2. That the Public Relations Committee be encouraged to continue the program as outlined the early part of the year, and that this committee be allowed sufficient funds whereby it may keep the public and the various social agencies informed as to what the profession is doing, and of our willingness to coöperate in any or all plans as related to the health and welfare of the people of our State.

3. That our relations with the allied professions not only be continued but be expanded where advisable. The value of this activity has been duly demonstrated during this past year in the joint activities of the Hospital Relationships and the Pharmaceutical Committees.

4. It is evident that we must adopt some continuous plans for protection from adverse legislation. This need has been well demonstrated in the present session, when the Uniform Medical Practice Act was assailed. Every member should appoint himself as a keyman in his community and see to it that the Legislators from his district are properly informed and persuaded to protect our interests, as well as the health of the public whom we serve.

5. That the efforts to amend some of the weaknesses in the Compensation laws be continued as a public service to the injured as well as an advantage to the profession.

6. That the splendid accomplishments of the Maternal Welfare Committee, Tuberculosis Committee and the Cancer Committee be recorded and their recommendations be continued.

7. That the recommendations as outlined by the Public Health and its sub-committees

be adopted. The needs for National Defense will include many of the plans as recommended by these several committees and should receive our whole-hearted support.

8. Medical Practice is still under fire and is receiving much consideration from State and national agencies in an effort to solve the problem. Post-Graduate Education properly carried on may well contribute to the solution of the problem of adequate medical care, for this must lie in keeping the profession on the alert and well informed as to the latest and most modern methods for treating the sick.

9. That the Clinical Conference meetings be continued but limited to one institution, and the Conference be arranged primarily to meet the needs of the general practitioner.

10. That the ad-interim meetings be carried on from year to year, whenever items of importance seem to require the consideration and vote of the House of Delegates before the next annual session.

COÖPERATION

In conclusion, may I state that the success of any Society, whether it be State or County, depends about ten per cent on its officers and 90 per cent on its individual members, and that which has been accomplished during this past year has been due to the keen interest and loyal support of both, for which I feel very grateful. With this continued effort we have every reason to believe that The Medical Society with all of its splendid traditions of the past will continue to protect the interests of the membership as well as the health and welfare of our people.

REPORT OF THE BOARD OF TRUSTEES

To the House of Delegates:

Up to the date of the preparation of this report eight meetings of the Board of Trustees have been held. The principal activities presented and considered are summarized as follows:

1. Election of Dr. Green as a member of the Board of Trustees to fill an unexpired term.

2. Selection of Newark as the site of the Annual Fall Clinical Conference.

3. Appointment of Medical Preparedness Committee with approval of their program and budget.

4. Approval of Medical Service Administration plans and budget for one-year experiment.

5. Assignment of Dr. Scott, Executive As-

sistant, as full-time Medical Director of Medical Service Administration for one year. Salary is provided by the Medical Society and charged to Medical Service Administration budget.

6. Approval of ad interim meeting of the House of Delegates and its agenda.

7. Election of W. F. Costello as Trustee member of the Finance and Budget Committee.

8. Re-appointment, at the request of the Legislative Committee, of Dr. Quigley as Executive Secretary of that Committee to November, 1941, at salary of \$2500 per year and five cents per mile travel allowance.

9. Election of Dr. Ewing as Honorary Member of The Medical Society of New Jersey.

10. Presentation of an award of merit to Dr. Eagleton.

11. Presentation of an award of merit for his work in Public Health Service to Dr. A. W. Bingham.

12. Nomination of Dr. Dilger to the Crippled Children's Commission at the request of that Committee.

13. Approval of 1941 Annual Meeting: dates, place and program.

14. Appointment of Business Organization Committee.

This Business Organization Committee has been appointed:

1. As a fact-finding and not a fault-finding body whose purpose is to survey the activities of the Executive Office.

2. To evaluate the programs of the various committees with a view of deciding what value the Society is receiving, professionally and economically, for the time and money expended.

3. To determine if possible, ways and means to curtail expenses.

4. To develop plans for the more complete and harmonious integration of the work of the various Committees and the Executive Office.

This Committee has received very fine co-operation from the Executive Officer and his staff and, judging from their preliminary report, we are convinced that many worthwhile suggestions will be made as a result of their studies.

In condensed form the activities enumerated may not appear very extensive, but to arrive at decisions, especially on problems of the Medical Service Administration and the Medical Preparedness Committees' work and the Annual Meeting Committee problems necessitated the expenditure of a vast amount of time, not only of all the members of the Board, but

also of additional time by members appointed on committees to make detailed studies of these problems.

To expedite the work of our Board it is earnestly requested that all Committee Chairmen keep in close touch with the Board's Chairman regarding material the committees wish to submit for the Trustees' consideration. If this material is submitted well in advance, the previous actions taken regarding it can be reviewed and a synopsis supplied to the Board members by the Executive Officer prior to the meeting, thus saving the time of our Board and insuring a better understanding of the matters to be discussed. The practice of certain Committee Chairmen in asking for a place on the agenda only twenty-four hours before a meeting—at which time the agenda is already filled—is unfair in that it does not permit the proper consideration of the subject to be discussed.

In conclusion, I wish to thank the members of the Board for having honored me with the privilege of acting as their Chairman. Their regular attendance at the meetings and their unselfish devotion to the problems presented have made my duties as Chairman most pleasant. The Trustees wish to convey to the various Committee members and their chairmen full appreciation for the coöperation shown, and to assure the House of Delegates that these committee members, despite the fact that in the inevitable though rare disagreements which may arise concerning policies or administrative procedure, both groups have always kept the best interests of The Medical Society as their foremost aim in all their considerations and decisions.

WILLIAM F. COSTELLO, *Chairman*
ALDRICH C. CROWE, *Secretary*.

REPORT OF THE EXECUTIVE OFFICER

By LEROY A. WILKES, M.D., Trenton, N. J.

To the President and the Board of Trustees:

The principal aim of the Executive Officer is to serve the Society and save the time and effort, insofar as possible, of busy practitioners. Curtailment of program and expenses can only be accomplished by sacrificing some of the work now being carried on; and since the programs were begun by order of the Officers and Committees, these officials will have to decide what, if anything, shall be curtailed.

Your Executive Staff is business-trained and

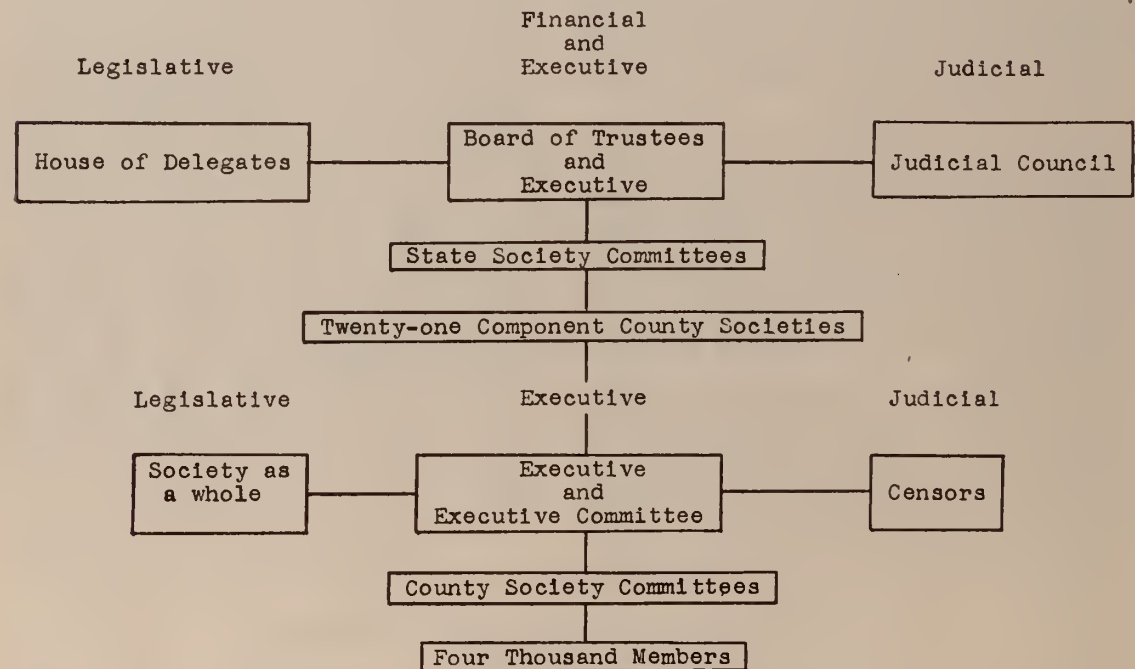
has a medical man of administrative training and ability to understandingly direct. Economy comes through elimination of duplications in effort and expenses. This means unification of direction, supervision and control of the mechanism of the Society. A girl in the Executive Offices, who is competent in her field, can, at considerable financial saving to the Society, do much of the work that physicians themselves would otherwise do for the Society, at a considerable personal and financial sacrifice.

We have in the Society 4000 physicians to establish policies and principles, and to approve plans and programs, and one physician-executive to provide for continuity of aim and effort through full-time service in the executive function. Eight years of experience with the present plan of organization provide a basis of review of the expanded program and cost. The present and future demands of the public determine the scope of services and cost of our programs.

During the current year the Executive Officer has not made as many visits to the County Societies as in the past. This was intentional because the two main projects of the Society this year have been the Medical Service

Administration and Medical Preparedness, and the County Societies have been kept well informed upon these projects through the Journal and through visits by the Executive Assistant, who more recently has worked directly under the Medical Service Administration and the Medical Preparedness Committee. President Morris has also visited each County Society and spoken about the activities of the State Society Committees. The Executive Officer has been busy with the other activities of the Society.

A review of the structure and functions of The Medical Society of New Jersey, presented in diagrammatic form, may serve a useful purpose in emphasizing our preparedness, as a Society, to provide a united front.



All aims, purposes, objectives, principles, and programs are first established by the Executive Board (Trustees); and on recommendation of this board, and by vote of the House of Delegates at Annual Meetings, they are sustained and made known to all concerned.

The programs are planned by Committees and scheduled by the Executive Office staff. The Committees and Society members concerned dispatch these schedules in carrying out the programs as planned, in accord with aims, policies and principles set by the Executive Board.

All activities of the State Society should be integrated through the Executive Staff for

economy and effectiveness. Only in this way may the investment in time and money-saving business equipment and knowledge be justified. Progress reports on costs and results are made to and weighed by the Trustees as they are periodically prepared by the Executive Officer and submitted to the Executive Board.

Such a plan conserves the time of the Board members at meetings, since prepared statements regarding the items on the agenda can be sent to Trustees in advance of a meeting. This procedure serves to reorient all the members, who are primarily engaged in other activities. The Trustees can, from the prepared report, discuss and approve such parts of the program,

activities and progress as they wish, and state objections to specific parts or make counter proposals for study and comment. Such a plan in no way removes control from the Trustees but provides factual data for their information and permits prompt and enlightened decisions to be made by the Board for the guidance of the Executive and Committee members.

While the "rugged individual" still exists, circumstances beyond his control have increased the trend toward group action in organized health activities, in which the doctor is taking part in his own community health programs. The war effort will further increase this trend toward group action and at least some of the liberalism and freedom enjoyed by the individual is likely to be curtailed. Organized effort brings efficiency and economy. Facts replace opinions wherever reliable data can be obtained. The physician is no exception and is already markedly influenced by current trends.

In the Society's Annual Reports of programs and procedure there is definite recognition of the need for professional services, planned to care for those individuals who do not exhibit sufficient initiative and intelligence to personally select and consult a physician of their own choice. This represents a large group and may increase in size, but private practice must always be available to those who demand and pay for such services. Group service plans are not all alike. They each provide a service on different levels of cost and effectiveness.

Even among the patients in higher income levels we find an increasing number of persons who take advantage of some of the medical service plans conducted with at least equal efficiency and provided at lower or through better distributed cost. Such plans are now available in certain pay "clinics" conducted in connection with hospitals (Mayo), Universities (Cornell), Private Group Practice (Reese-Loose and others), some industries (Endicott-Johnson), private schools, and through insurance plans with selected personnel and facilities, such as those of the Medical Service Administration.

Certain of these agencies are efficient and economic because the medically trained staff, and also the business staff are especially trained and experienced in the special field in which they are engaged, i. e., the surgeon is left free to do surgery, and the executive is recognized as most competent in business methods. Both workers must have the same aims, the confidence and coöperation of the other, and the liberty of action within established principles and policies, necessary to achievement. Occasionally the surgeon may also be a trained

executive—or the executive may also be a surgeon, but this situation is incidental and exceptional, and in such cases where the dominant interest and ability of the individual lies in one field, to which he eventually and wisely restricts himself. Plans and schedules are the basic concern of executive officers carrying on programs arranged by the executive board. The Executive Officer in The Medical Society of New Jersey is the full-time liaison officer between the Executive Board and the component Societies, and between the Society and the Committees or individuals to whom are assigned specific jobs. He, as the continuing link, must keep each of these two groups informed of the needs and accomplishments of the other, and of what has previously been tried out or accomplished. He alone is *continuously* "on this job" and oriented in the details of the Society's activities and progress.

Delegated authority implies confidence and the support of the Society as a whole. Those to whom such authority is delegated must be expected to fully assume it and discharge their duties promptly if action and achievement are to result. This applies to the Society's Officers and Committees, and to the Staff,—authority makes leadership possible.

Physicians should, above all other individuals, appreciate the need for prompt action, and the danger and cost involved in delay. Yet one of the most conspicuous weaknesses in our organization, as compared to many other community service organizations, lies in the excessive amount of time consumed in and between conferences, and the influence of this delay in action and achievement. The conduct of organized medical effort cannot be left, in these strenuous days, entirely to the spare time of busy practitioners. Their advice is needed but staff members can, at lower cost and usually more effectively, because of their experience and available time, aid in the accomplishment of the stated aims of the Society, when they receive the necessary authority, support and confidence from the Officers.

Our Constitution and By-Laws are wisely drawn and provide the essentials of good business procedure. The Society was originally envisioned as a "brotherly association" with professional, scientific excellence as the primary aim, through constant efforts at improvement. Now economic security must also be assured and be based upon a demonstrated and publicly accepted superiority in the field of medical practice.

The economic problem of the profession today centers primarily about the *equitable distribution* of medical service at a fair cost to

the public—in all the economic levels; but those of low intelligence and initiative must be screened for defects and disabilities. This screening can best be done in groups at school, at work or at other centers where people must gather for purposes other than health. From the public health viewpoint of conservation and control of epidemics this lower initiative group is the most important group to examine in order to detect early departures from the normal.

The fair and equitable solution of any medical service problem, through effective and practical ways and means, should not be impossible. The government could pay for medical services rendered only to those in need thereof, and who through investigation are found willing but unable to meet their obligations. The removal of such a financial and physical burden from the shoulders of the general practitioner would allow him more time to devote to his patients and to further perfect his knowledge and technique. It would also provide experience and some contribution toward the expense of the younger practitioners under the supervision of their more experienced colleagues.

Revolutionary changes do not seem as near now as last year, but *evolutionary* developments are everywhere evident and many are already in the experimental stage. The medical profession will benefit from newer knowledge and procedure once its value is firmly and scientifically established.

The Executive Offices this year have taken over the entire handling of the technical exhibits. This will increase the return to the Society by \$1000 this year, making a total net income of about \$4500 from the technical exhibits. Another considerable saving will be made through new arrangements for staging our scientific exhibits.

Further economies are possible through centralization of effort and equipment and without sacrifice of aim, policy or principles so far as the welfare of the Society is concerned. Business methods are not incompatible with professional security or ethics. They should and do complement the professional practice in the best hospitals and clinics (such as Mayo and Lahey Clinics), and in the best conducted offices of successful private practitioners of medicine.

The needs of today and the organization structure of our Society are such that the Society designed originally as a "brotherly association" of professional colleagues cannot adequately fulfill its function and a service agency directing the distribution of medical care is needed. The Medical Service Administration,

sponsored by The Medical Society of New Jersey, is an experimental set-up to meet just this need. As such it deserves your full support and coöperation. The intent is to substitute constructive action, for the criticism which at times has not been helpful. In order to judge fairly the merits of the plans offered, the administration of the experiment, or the public demand for such plans, every participating physician must study the rules carefully and play the game fairly and to the best of his ability. The part for which the members of organized medicine have been trained is not materially changed, and the profession has assumed the responsibility and has provided the money to start the experiment. Each must do his part.

The Executive Office budget has not been exceeded, the staff members are loyal and efficient and the work has been economically done. With adequate confidence in and support for the staff, much of the physicians' time can be saved by confining the efforts of these physicians to guidance and aid in medical matters, and the time of the executive staff to those procedures essential to economy and achievement through effective integration and flexible application of effort. This development has progressed so far that the Executive Officer is devoting more time to contacts and coöperation with other state and community professional groups, with whom our work in the Medical Society may be effectively integrated or may definitely conflict unless continuing liaison provision prevents.

One of the most important and economic controls on Medical Society expenditures is the "cost-accounting" studies carried on with the occasional help of the auditor and the interest and approval of the Finance and Budget Committee. With these facts available and by the limited use of a requisition system a more economic use of budgetary funds can be assured through estimates of cost more available *before* expenditures are made. Such efforts to insure these savings have at times been interpreted as critical instead of analytical in character, and have tended to discourage the presentation of such data to the Society, though the Executive would cease to be true to himself as well as to his organization if he did not gather and benefit from facts essential to successful conduct of his responsibilities.

The President's Report has summarized the activities of the Society, and the Committee Reports provide the details of their respective contributions. The Treasurer's Report discloses the cost and the general distribution of expenditures. The expenditures were ordered and approved by the appropriate and duly elected rep-

representatives of our members. The Executive Offices' expenditures cover only the monthly carrying charges and salaries of the office staff, and are accounted for monthly to the Finance Committee and to the Treasurer.

The demands upon the office staff have been heavy due to the unusual demands incident to medical preparedness which was unforeseen, and the Medical Service Administration, prior to its removal to its own offices. This is not a criticism but an explanation. The Executive Assistant was relieved for a period up to one year and assigned to these two projects exclusively. The support of these two projects by the Society is vital if we are to carry out what we have definitely committed ourselves as a Society to insure. Economy is being more than ever stressed and we must be sure we provide real economy. Curtailment of expenditures is

not always economic. There are times, however, when no choice is left. The most careful consideration and discussion should precede decisions on such a vital subject at all times, but especially when we should be prepared to meet unexpected developments and demands. The Trustees are carefully considering this problem and will present their views to the House of Delegates in due time.

President-Elect of the American Medical Association, Dr. Lahey, in his recent address in the Town Hall Series in Newark, presented the fairest and most convincing arguments for retaining the proven parts of medical practice and through evolution to adapt to our established needs the best of what is new.

Respectfully submitted,
LEROY A. WILKES, M.D.,
Executive Officer.

REPORT OF THE JUDICIAL COUNCIL

By CHRISTOPHER C. BELING, M.D., Newark, N. J.

To the House of Delegates:

During the past year no official communications were received by the Judicial Council.

The condition of the profession throughout the State seems to be satisfactory.

FIRST COUNCILOR DISTRICT

Union, Warren, Morris and Essex Counties

By CHRISTOPHER C. BELING, M.D., Councilor,
Newark, N. J.

To the House of Delegates:

During the past year no matters of an ethical nature were referred to the Councilor of the First District.

SECOND COUNCILOR DISTRICT

Sussex, Bergen, Hudson and Passaic Counties

By VINCENT P. BUTLER, M.D., Councilor,
Jersey City, N. J.

To the House of Delegates:

The same high standard of medical ethics which has been practiced in the past still prevails and there have been no matters calling for action of the Judicial Councilor of the Second Judicial District.

THIRD COUNCILOR DISTRICT

Mercer, Middlesex, Somerset and Hunterdon Counties

By BARCLAY S. FUHRMANN, M.D., Councilor,
Flemington, N. J.

To the House of Delegates:

There have been no problems for the Third Judicial Councilor of this district during the past year. The county societies in this district are functioning well, and considerable effort is being put forth by the respective officers to see that such a condition continues to prevail.

FOURTH COUNCILOR DISTRICT

Camden, Burlington, Ocean and Monmouth Counties

By S. EMLÉN STOKES, M.D., Councilor,
Moorestown, N. J.

To the House of Delegates:

I am glad to report that during the fiscal year just ending no problems have been brought to

the attention of the District Councilor by the Societies in the Fourth Councilor District. From all indications peace and harmony have prevailed.

I am delighted to report no need for my services during the year, but assure the officers and members of each of the County Societies in this district of my sustained interest in their work, and willingness to serve whenever they feel I can be of assistance.

FIFTH COUNCILOR DISTRICT

Atlantic, Cape May, Cumberland, Gloucester and Salem Counties

By CHESTER I. ULMER, M.D.,
Gibbstown, N. J.

To the House of Delegates:

A meeting of the Fifth Councilor District was held in Woodbury on December 19, 1940.

This meeting was sponsored by the Gloucester County Medical Society. The speakers were Dr. Frank H. Lahey, President-Elect of the American Medical Association, and Dr. Thomas K. Lewis, President-Elect of our State Society. There was a large attendance of members from the five County Societies in the district.

The Councilor feels that a District Meeting should be held every year, if possible. They promote a spirit of fellowship among the members and tend to increase the solidarity of our State organization.

Two cases of alleged malpractice were brought to the attention of the Councilor. One case came to court trial, the other was settled outside. The Councilor was able to assist both members in the satisfactory settlement of their cases.

ANNUAL REPORT OF THE SECRETARY

By ALFRED STAHL, M.D., Newark, N. J.

To the House of Delegates:

MEMBERSHIP

On March 15, 1941, the Official List consisted of 3,897 members, of which 3,768 were active members and 129 associate members. This is an increase of 113 active members over last year.

Deaths of Members	32
Transfers from other states	13
Transfers to other states	5
Transfers from one county to another within New Jersey	10
New Members and reinstated Members . . .	271
Former Members not paid up for 1941 . . .	311
Non-members, physicians, including those residing in New Jersey but not licensed to practice in the State and are practicing in other states; those retired; former members who have resigned; resident physicians in hospitals, etc.	1600

175TH ANNIVERSARY

This year marks the 175th anniversary of the founding of The Medical Society of New Jersey. To commemorate this occasion a special anniversary number of the Official List was prepared. In addition to the usual list of members arranged alphabetically and by county societies, an outline of the history of the Society has been added, together with photographs of the Officers and Committee Chairmen of

The Medical Society of New Jersey. Photographs of the officers of each of the twenty-one county societies appear at the head of each County Society membership list. This special issue of the Official List has been dressed up in an attractive blue cover. The Secretary trusts that his efforts in this direction meet with the approval of the members, as well as the Officers and Trustees of The Medical Society of New Jersey.

AMERICAN MEDICAL ASSOCIATION

On April 1, 1940, the American Medical Association made the triennial apportionment of the membership of its House of Delegates. This apportionment is to become effective at the next succeeding annual session.

By virtue of this reapportionment, The Medical Society of New Jersey has been allotted an additional delegate to the present four delegates. This additional delegate as well as delegates for the expiring terms of the present delegates will be elected at the Annual Meeting of The Medical Society of New Jersey in May.

PRIZE ESSAY AWARD

Ten original papers have been received by the Secretary from as many members of The Medical Society of New Jersey to compete for

the prize of \$100.00 and the privilege by the author of reading his paper at the Annual Meeting. These papers are now in the hands of a secret committee which will decide the winner. The Secretary is the only one who knows the identity of the contestants, and he won't tell.

COUNTY SOCIETIES

During the past year your Secretary has mailed letters to the Officers of each County Society, calling their attention to Chapter IX, Section 2, of the By-Laws of the State Society:

“(a) Annual Assessment of Members. On the first day of January in each year there shall be levied on each component society a per capita assessment on the membership of such component society, as hereinafter set forth (Par. b), to be paid to the Treasurer of The Medical Society of New Jersey not less than five days before the fifteenth of March, together with a list of the members for whom such payment is made. *A similar per capita assessment shall be paid in the same manner immediately upon the admission or reinstatement of any such member*, except that for a new member admitted after October first of any calendar year, one-quarter of the regular assessment shall be paid. Every member for whom the assessment is paid shall be listed as

a subscriber to and entitled to receive the Journal.”

It is imperative that this provision be strictly complied with, so that new and reinstated members have prompt access to the several privileges of membership, such as the subscription to the State Journal, fellowship in the A. M. A., medical defense insurance, staff membership of hospitals, etc.

SPECIAL MEETING OF THE HOUSE OF DELEGATES

Notices of a special meeting of the House of Delegates and credentials for the same were mailed to all Officers, Fellows and Delegates on November 6th, 1940, by the Secretary.

On November 28, 1940, at 2:00 p. m., the ad interim meeting of the House of Delegates of The Medical Society of New Jersey was called to order by President Watson B. Morris at the Academy of Medicine auditorium in Newark. This meeting was well attend. One hundred and sixty Delegates were present.

The Secretary desires to bear witness to the high degree of harmony and spirit of devotion to the cause of organized medicine shown by the Officers and Committeemen of The Medical Society of New Jersey and each of the twenty-one component county societies.

Respectfully submitted,
ALFRED STAHL, M.D., *Secretary*.

REPORT OF THE TREASURER

By GEORGE J. YOUNG, M.D., Morristown, N. J.

To the House of Delegates:

The fiscal year of the Society does not close until May 31st. A complete financial report

will be presented directly to the House of Delegates.

Respectfully submitted,
GEORGE J. YOUNG, *Treasurer*

REPORT OF THE DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

By WELLS P. EAGLETON, M.D., Newark, N. J.

To the House of Delegates:

A brief report will be made to the Delegates at the time of the Annual Meeting.

Yours truly,
WELLS P. EAGLETON.

REPORT OF THE FINANCE AND BUDGET COMMITTEE

By HARRY R. NORTH, Chairman, Trenton, N. J.

To the House of Delegates:

The Committee on Finance and Budget cannot prepare its report until a few days before the close of the fiscal year. It will submit its

report directly to the House of Delegates on the first session of the Annual Meeting.

Respectfully submitted,

HARRY R. NORTH, *Chairman*
HERSCHEL PETTIT
ANDREW F. MCBRIDE
DAVID B. ALLMAN
HENRY SPENCE
WILLIAM F. COSTELLO
GEORGE J. YOUNG

REPORT OF THE COMMITTEE ON HONORARY MEMBERSHIP

By EDWARD J. ILL, M.D., Chairman, Newark, N. J.

To the House of Delegates:

The Committee on Honorary Membership has no report to make just now. A report will

be made to the House of Delegates at the time of the Annual Meeting.

Respectfully submitted,

EDWARD J. ILL, *Chairman*
LANCELOT ELY
E. ZEH HAWKES

REPORT OF THE COMMITTEE ON MEDICAL DEFENSE AND INSURANCE

By CHRISTOPHER C. BELING, M.D., Chairman, Newark, N. J.

To the House of Delegates:

Twenty years ago The Medical Society of New Jersey instituted the present plan for the professional protection of its members. During this period its Committee on Medical Defense and Insurance has carried on the work through the same agencies which were selected at the start. Prior to 1921 the State Society protected its members under its own Medical Defense Act in a more or less limited manner. It paid a reasonable sum of money to defend a member but did not provide for the payment of damages awarded by juries. For some years after the institution of the new plan many members still continued to avail themselves of the defense furnished by the Society. This year, out of a total membership of 3897, according to available returns, 3208 members have availed themselves of protection against malpractice suits, an increase of 100 over the past year. There are about 311 delinquent members. It is important for these members to take cognizance of the fact that unless their dues are paid up their insurance policies are not valid.

During the period from June 1, 1940, to

March 1, 1941, fifty malpractice claims were reported. Of this number, eight were on account of diathermy burns, five for improper diagnosis, four for negligence in the treatment of fractures, and three for needles broken in the body during injections. Among other causes were incorrect diagnosis, improper treatments, and failure to obtain consent for operation.

The Company refused to renew the policies of two doctors. Both of them appealed to the Committee. After a careful study of the facts and matters pertaining to their cases, on favorable recommendation by the Committee, the risks were accepted. The Company takes the position that a few doctors who are grossly negligent can cause such expense as to make it unprofitable to carry the contract at current rates and that the cost of insurance will have to be substantially increased. In one of the States the experience has been so bad that the Insurance Companies have withdrawn from the field of malpractice liability insurance. In New Jersey the careful selection of risks, the requirements of high standards for special practice, as in Roentgen and radium therapy, and

the coöperation of the Committee have to a considerable extent kept down the number of suits. This year a verdict for \$50,000 in a suit brought against a doctor for improper use of the x-ray in treatment is now on appeal.

The attention of the Committee was drawn to the case of a physician who made application for membership in a County Society and was placed on probation for a period of one year without any kind of membership. He could not obtain the State Society's policy and had to be satisfied with a restricted form of policy issued by another company. For the lack of proper protection a claim against him proved very costly.

By direction of the President our Committee brought the matter to the attention of the County Societies, so that each component Society would set up a class of membership in conformity to the By-Laws of the State Society to enable the younger doctors starting practice to get the proper insurance.

The Committee takes this opportunity to thank the County Societies for coöperation in this matter as well as in many other matters pertaining to medical defense; the Insurance Company for its continued coöperation and our official broker for his untiring services.

Today the strength of our medical defense is due to the close coöperation of the Insurance Company and the Committee of the State Society. In every case when a suit is threatened or instituted it is immediately brought to the attention of the Committee and is thoroughly investigated by the Company. The liaison between the company and the Committee has been made more and more effective each year. There is still much to be obtained in the way

of coördination. We need the help of every member in our Society. Last year many instances came to the attention of our Committee where policies were obtained from extraneous sources and no attention had been given to details which were so important for the doctor's interest.

We urge every member to take his insurance through the recognized official source so that our organization can be further improved and coördinated.

ACCIDENT AND HEALTH INSURANCE

The holders of the new policy exceed in number the policyholders under the old form of policy which had been in existence for ten years.

The financial statement of the National Casualty Company as of December 31, 1940, shows that the Company has \$1.78 of assets for every \$1.00 of liability.

RECOMMENDATIONS

We recommend the renewal of the contract with the United States Fidelity and Guaranty Company of Baltimore for the ensuing year through Messrs. Faulhaber and Heard, our official broker. The Committee also recommends the renewal of the contract with the National Casualty Company for the ensuing year through Messrs. E. & W. Blanksteen, our official broker.

Respectfully submitted,

CHRISTOPHER C. BELING, *Chairman*
J. WALLACE HURFF, *Vice-Chairman*
WILLIAM C. WESCOTT
CHARLES F. BAKER
CHARLES J. LARKEY
E. ZEH HAWKES, *Consultant*

REPORT OF THE PUBLICATION COMMITTEE

By HENRY C. BARKHORN, M.D., Chairman, Newark, N. J.

To the House of Delegates:

The principles and detailed functions of the Publication Committee have been given in previous reports, and may be found in annual reports of this committee of preceding years.

The Journal is not only a scientific journal, but records in detail the activities of the Society as a whole, as well as the activities of the component County Societies and the Woman's Auxiliaries.

The advertising is carefully selected and helps defray part of the cost of producing and distributing The Journal.

The Journal in its present form is a source of interesting and helpful information to other state societies with whom we exchange ideas through our respective journals. It is helpful also in interpreting to other state agencies our program and plans, and in this way promotes coöperation of personnel and integration of activities for the better distribution of medical services.

Since reports of all activities in the Society are submitted to the Executive Office and are brought to the attention of the Editor, each member has the opportunity to keep abreast of

the developments as they emerge in the evolution of medical service. No member can afford to miss the opportunity provided through The Journal if he aspires to progress with his profession in meeting the changing trends as they are indicated.

CONTENTS OF THE JOURNAL

Following the custom of recent years, the Publication Committee submits the following table showing the number of pages in each department of The Journal, exclusive of the supplements:

1940	Editorials	Original Articles	State Society Activities	County Society Reports	Woman's Auxiliary Activities	Total Reading Pages	Pages of Advertising (Including Cover)	Total Pages in Monthly Issues
January	6	19	13	6	2	46	38	84
February	4	16	15	11	2	48	36	84
March	4	17	17	7	1	46	38	84
April	4	16	15	10	3	48	36	84
May	4	.	102	..	..	106	66	172
June	2	32	7	11	..	52	40	92
July	2	24	19	3	..	48	36	84
August	4	25	11	2	..	42	46	88
September	6	31	11	..	..	48	34	82
October	4	20	14	4	..	42	42	84
November	4	10	13	10	1	38	38	76
December	2	31	23	6	2	64	34	98
Totals for 1940	46	241	260	70	11	628	484	1112
TOTALS								
1939	50	334	270	80	24	758	482	1240
1938	56	323	236	92	31	788	468	1256
1937	66	385	181	108	34	774	510	1284
1936	72	380	173	98	25	746	366	1112

NUMBER OF PAGES IN THE JOURNAL OF 1940, BY DEPARTMENTS

ADVERTISEMENTS

Included among the advertising pages are those devoted to *Society Organization*, as follows:

The index of the reading pages, which appears on the first cover page of each Journal 12 pages
 The list of officers and committees on advertising pages iii-vii 42 pages
 (Since July, 1940, the list of officers and committees have been published quarterly instead of monthly, in the interest of economy.)

Total 54 pages

SUPPLEMENTS

April, 1940—Official List 68 pages
 May—Medical Service Administration.... 20 pages
 July—Medical Service Administration.... 4 pages
 August—Medical Service Administration. 4 pages
 August—Transactions 44 pages
 September—Medical Service Administration 4 pages
 October—Medical Preparedness 8 pages
 November—Fall Clinical Conference 8 pages

Total 140 pages

RECEIPTS

From June 1, 1940, to April 15, 1941

Turned over to Dr. Young, Treasurer. \$11,626.08
 On hand 800.30

\$12,426.38

Estimated receipts to May 31, 1941.. 2,205.00

\$14,631.38

EXPENSES

From June 1, 1940, to April 15, 1941

Journal \$10,584.49
 Reprints 114.75
 Supplement 250.82

\$10,950.06

Estimated expenses to May 31, 1941.. 3,022.00

\$13,972.06

Respectfully submitted,

HENRY C. BARKHORN, *Chairman* (1942)
 J. LAWRENCE EVANS (1941)
 EDWARD J. ILL (1943)
 WATSON B. MORRIS, *Ex-Officio*
 ALFRED STAHL, *Ex-Officio*
 FRANK OVERTON, *Editor*

REPORT OF THE WOMAN'S AUXILIARY ADVISORY COMMITTEE

By WILLIAM K. CAMPBELL, M.D., Chairman, Long Branch, N. J.

To the House of Delegates:

The Committee met with Mrs. R. J. McDonald, President of the Auxiliary, and her Committee at the Academy of Medicine, Newark, N. J., in the early Fall of 1940; and with the help of Dr. Watson Morris, President of the State Society, and of Dr. Robbins, Chairman of the Public Relations Committee, considered the program for the year's work as presented by Mrs. R. J. McDonald and her Committee.

After full discussion the program was approved by Dr. Watson Morris and by this Committee.

On January 13, 1941, at the invitation of the Woman's Auxiliary, the Chairman of the Advisory Committee met with them at their mid-winter luncheon at the Trenton Country Club and addressed them on the "Relation of the Auxiliary to the Individual Physician".

The Woman's Auxiliary seems to be working very efficiently and has not found it necessary to call on the Advisory Committee for anything more than routine approval.

Your Advisory Committee would however urge a greater effort on the part of The Medical Society of New Jersey to get better cooperation of those few County Societies who as yet have no organized Auxiliaries and thus are not only losing the advantages of such Auxiliaries to themselves but are standing in the way of the State Auxiliary by not giving it the chance to have full contact with many active individuals and much valuable material.

Respectfully submitted,

WILLIAM K. CAMPBELL, *Chairman*
GUSTAV A. BRAUN
HARROLD A. MURRAY
HAMMELL P. SHIPPS
ILY R. BEIR
ANDREW F. MCBRIDE, *Consultant*

REPORT OF THE COMMITTEE ON POST-GRADUATE EDUCATION

By STUART Z. HAWKES, M.D., Chairman, Newark, N. J.

To the House of Delegates:

During the year of 1940-1941, the Committee on Post-Graduate Education has continued its activities under the auspices of the Extension Division of Rutgers University. Courses have been conducted by the County Medical Societies in conjunction with Rutgers University and the State Society. The courses consist of six to eight lectures on diversified subjects. The subject matter is chosen and speakers are obtained at the individual wishes of the County Societies. A blanket fee is paid to Rutgers University to cover the expense of the courses; any fees over and above this amount are retained in the county treasury. This year courses have been conducted in Morris, Camden, Gloucester, Atlantic, Cape May, Middlesex, and Sussex.

Several new functions have been added. An affiliation has been formed with New York University for clinical teaching in the Newark City Hospital. Six to eight-week refresher courses are being given for men throughout the State. The courses are limited in number to allow close supervision and instruction of the individual doctor. During the year courses

have been conducted in Peripheral Vascular Diseases, Fractures, Disease of the Biliary Tract, and Amputations. Each of these courses has been very well received by the profession as is shown by the over-subscription in each enrollment. Doctors have been obtained from all parts of the State except the most southeastern counties. The committee feels this is a very great advance, as it is the first time the State has provided clinical bedside organized teaching in accepted post-graduate form.

Another effort has been to publicize and organize *teaching ward-rounds* in the Essex County Institutions, and to make the men feel free to attend them. In the past some doctors have not availed themselves of teaching material at hand because of a feeling of not being invited or welcome,—a situation which in most cases has existed only in the minds of the individual. It is hoped that the lead of Essex may be followed by other counties.

The State Committee has also coöperated with several County Societies in promoting clinical teaching efforts of their own. Bergen County conducted a six-week course in Peripheral Vascular Diseases, and the Physical Ther-

apy Committee in Essex County had a course in Office Physical Therapy. Both of these courses were open to men throughout the State. The committee also collaborated with the Tuberculosis Sub-Committee, of the State Public Health Committee, in promoting and developing a course in tuberculosis in Hudson County. All these courses were very well received and should point the way to further developments in other counties.

The State Committee is also attempting to classify, codify, and evaluate teaching facilities in nearby states, so that it may act as a central clearing house of knowledge in this field. It is attempting to place information as to opportunities outside the State in the hands of those who are interested, and who cannot gain the desired instruction within the state. It has also attempted to keep abreast of national developments and promote those which seem of profit to our membership. It is felt that in the past

we as a Society may have leaned too heavily on the large educational centers outside our State, to the detriment of our own individuality and advance.

It is becoming more and more apparent that there are ample facilities for clinical teaching in many parts of the State which are not being used to the greatest possible benefit.

The committee wishes to heartily thank Dr. R. H. Light, who has had charge of the work of the Rutgers University Extension Division; the many busy teachers and instructors who have given so freely of their time and efforts to help us in making this program a success; and the offices and officers of the State Society for their coöperation.

Respectfully submitted,

STUART Z. HAWKES, *Chairman*
DAVID F. BENTLEY, JR., *Vice-Chairman*
SLOAN STEWART
HAMMELL P. SHIPPS
ALBERT W. PIGOTT
THOMAS K. LEWIS, *Consultant*

REPORT OF THE COMMITTEE ON ANNUAL MEETING

By J. CARLISLE BROWN, M.D., Chairman, Atlantic City, N. J.

To the Board of Trustees:

The principal objective in preparation for the Annual Meeting of 1941 has been the production of a program which would interest all the members of our Society.

The scientific sessions, under Dr. Clarence Andrews, will present subjects of broad general interest and significance. A special effort has been made by Dr. W. W. Hersohn to arrange scientific exhibits which correlate with the scientific programs.

It is hoped that the arrangement of the program will give ample opportunity for attendance at the various meetings and business sessions; and also provide an abundance of time for the enjoyment of scientific exhibits and social events.

At the Special Meeting Wednesday morning a forum on public health activities in the State will be held. The various activities of medical importance of the Department of Public Health, Department of Institutions and Agencies, the Hospital Association, the Tuberculosis League, and the Motor Vehicle Department

will be presented by speakers representing these departments.

Ample opportunity will be given for asking questions at the end of the session.

A large section in the Scientific Exhibit has been reserved for the exhibition charts, pictures, etc., which will demonstrate graphically the function of these agencies.

Your Committee believes that the subjects to be discussed at the sessions are of importance to all members and urges a large attendance.

Every effort has been made to provide a social program which will make your leisure hours memorable.

The 175th Annual Meeting of The Medical Society of New Jersey offers an unusual opportunity for a vacation during which you may refresh your mind and body and have a good time.

Respectfully submitted,

J. CARLISLE BROWN, *Chairman*
WILLIAM J. CARRINGTON
CLARENCE L. ANDREWS
WILLIAM W. HERSOHN
THOMAS MCG. BRENNOCK

REPORT OF THE SCIENTIFIC PROGRAM COMMITTEE

By CLARENCE L. ANDREWS, M.D., Chairman, Atlantic City, N. J.

To the Annual Meeting Committee:

I have the honor of presenting to you the annual report of the Scientific Program Committee for 1941. You will observe several departures from the customary set-up of the scientific sessions as compared to those of the past few years, and your committee hopes that you will accept these changes as evidence of our desire both to improve the attendance and to re-arouse interest in the programs as presented, instead of suspecting an attempt on our part to "run things" by instituting drastic changes just for the sake of doing something different.

First of all, it has become more and more apparent to all concerned for the past few years that there was something radically wrong with our program policy. The attendance of scientific meetings has been getting poorer and poorer from year to year, in spite of outstanding speakers who have presented up-to-the-minute data wholly in keeping with those read before the A. M. A., and the American College of Physicians. Moreover, this great lack of interest cannot be ascribed to a conflict between business and scientific sessions, because the various committees on arrangements have constantly seen to it that nothing occurred during the allotted section hours that could in any way detract members from the scientific sessions.

In other words, it seemed apparent to us, that the Society, through the adding of more and more sub-sections had failed to accomplish what it had intended to and the time seemed well at hand to seek the cause or causes for such a retrogression.

The prime reason for creating the various sub-sections, as your committee understands it, was the hope of promoting a larger general attendance, and to assist in developing a greater number of good clinicians by giving more of them space on the program. If the latter has improved, the former has greatly suffered.

So few have attended the various section

meetings during recent years that section chairmen have felt compelled to apologize to visiting speakers in order to assure them that the meagre audiences did not reflect the membership's regard for them as speakers.

Such a status of affairs neither advances the cause for which it was intended, nor does it reflect creditably upon the society as a scientific body. Hence, it was unanimously decided to stop and "take our bearings", as it were, and try to determine just what the membership really wanted.

To facilitate such a "stock taking", it was thought best to eliminate all sub-sections for 1941 entirely and substitute for them two general sessions so designed as to appeal to every member of the Society of whatever specialty, and then to compare the results of such a program with those of the past few years.

From this temporary change, if it becomes evident that the followers of the various sub-sections still wish to carry on, it would then become incumbent upon the House of Delegates in the annual session, to decide whether it wishes to continue as in 1941 or revert back to the sub-section arrangements of previous years.

Finally, it was the opinion of our committee that if the sub-sections wished to continue as they have done in the past, that it might be best to hold the sub-section meetings during the Clinical Conference in the Fall at Newark. Newark is nearer the center of medical population and would offer a second advantage of being nearer the large hospitals where clinical facilities are available if so desired and section clinics could be had instead of the reading of didactic papers.

The program follows:

Respectfully submitted,

CLARENCE L. ANDREWS, *Chairman*
GEORGE N. J. SOMMER, JR.
STUART Z. HAWKES
THOMAS B. LEE, *Consultant*

PROGRAM OF THE 175TH ANNIVERSARY MEETING THE MEDICAL SOCIETY OF NEW JERSEY MAY 20, 21, 22, 1941

TUESDAY MORNING
10:30—Meeting of House of Delegates (Short Session)

AFTERNOON
2:30-4:30—General Medical Session

EVENING
7:30—Reference Committees

WEDNESDAY MORNING
10:30-12:50—175th Anniversary (Special Session)

AFTERNOON
2:30-4:30—General Surgical Session

EVENING
7:30—President's Reception and Banquet

THURSDAY, 10 A. M.-1 P. M.
Final Meeting of House of Delegates

REPORT OF THE COMMITTEE ON SCIENTIFIC EXHIBITS

By WILLIAM W. HERSOHN, M.D., Chairman, Atlantic City, N. J.

To the Annual Meeting Committee:

The work of the Committee is progressing satisfactorily, and an exhibit of good calibre is assured. Individual booth requirements will be somewhat larger than last year, and the total number of exhibitors slightly smaller. New Jersey exhibitors will be represented to a greater extent than in other years. It is gratifying to see this increased interest on the part of our members.

To effect a rather marked economy in the conduction of the Scientific Exhibit, our permanent material has been disposed of to avoid

storage charges, and the entire set-up will be handled through new arrangements on a rental basis.

The Committee has this year given over an appreciable amount of floor space to various State agencies with which the Society coöperates closely. This is an innovation, and adds a new educational type of exhibit to the existing technical and scientific exhibits.

Respectfully submitted,

WILLIAM W. HERSOHN, *Chairman*
ROBERT B. DURHAM
SLOAN G. STEWART
HARRY R. NORTH, *Consultant*

REPORT OF THE WELFARE COMMITTEE

By HILTON S. READ, M.D., Chairman, Atlantic City, N. J.

To the House of Delegates:

The Welfare Committee has had three meetings during the present administration with good attendance and endeavor on the part of the members. In addition we have had opportunity to welcome many of the State and County Society Officers and members of Advisory Committees, as well as liaison representatives of the State Health Department, Department of Institutions and Agencies, Board of Pharmacy, and the State Dental and Nurses' Associations, and invite their counsel. Many of our members have served long and faithfully and have, at great personal sacrifice, contributed to the evolutionary development of medical service in our State.

An experiment has been under way during the last three years as to the composition, size and procedure in making the Welfare Committee best serve its purpose. We have increased the number of members beyond the thirty-five prescribed in the By-Laws—a procedure provided for in the By-Laws—and opinion is divided as to whether this has proven to be an advantage or not.

There are four Sub-Committees to the Welfare Committee—Medical Practice, Public Health, Public Relations, and Legislation. To each of these "may be" appointed, for one year, Advisory Committees. These Advisory Committees were created by an act of the Board of Trustees, and approved, through acknowl-

edgment of their reports, by the House of Delegates. The members are appointed by the President. The Sub-Committee Chairmen are appointed by the Chairman of the Welfare Committee with the approval of the President. The Advisory Committee Chairmen are chosen by the Sub-Committee Chairmen to which they are advisory, and recommended to the President for appointment. The Welfare Committee is a Standing Committee and reports directly to the House of Delegates. The report of the Welfare Committee should contain the approved portions of the reports of the Sub-Committees, which in turn contain the approved portions of the Advisory Committee reports. To date all committee reports have been printed in full as a matter of record, but this procedure may be changed at any time by the Board of Trustees.

We have experimented with having Advisory Committees originate and present to Sub-Committees problems with recommendations for the final decision of the Welfare Committee. Some members feel that all subjects should first be presented to the Welfare Committee and referred, when advisable, to the Sub-Committee, and if necessary for special study to the specialized groups comprising the Advisory Committees. No final decision has yet been agreed upon.

The meetings have been begun and ended on scheduled time, without undue haste but without needless waste of time and effort. In

this endeavor we have had many expressions and evidence of support by the members.

The Advisory Committees should be kept at a minimum consistent with the problems faced by the Society, and they should be kept busy to justify their appointment. These committees need to be reviewed each year, and only those necessary to carry on the work continued, so as to provide a minimum demand upon the members' time, when the need is diminished. These Advisory Committees make two types of contribution:

1. Purely factual and informational.
2. Controversial and requiring decision and discussion by the Welfare Committee.

The Sub-Committees provide review and balance through their consideration of all of the recommendations of the Advisory Committees. Final decision representing the profession's attitude in New Jersey is made by the Welfare Committee.

The President has addressed the Welfare Committee at each meeting. The Committee,

after discussion, has approved all Sub-Committee reports as submitted at each meeting. The committee members have been informed, through the special progress reports, of the Medical Service Administration and the Medical Preparedness Committee activities.

The sentiment of the majority in the committee was in favor of omitting Medical Society assessment for members of County Societies in military or naval services, but this was found to be impossible of achievement since it is unconstitutional and contrary to our Charter as a Society.

The Welfare Committee endorsed the proposal to continue the Governor's Council on Health and Welfare appointed by Governor Moore.

The important parts of the informational and controversial reports received will be found in other reports.

HILTON S. READ, Chairman,
and his seventy-eight associates
on the Welfare Committee.

REPORT OF THE SUB-COMMITTEE ON LEGISLATION

By B. S. POLLAK, M.D., Chairman, Jersey City, N. J.

To the Welfare Committee:

The Legislature, which has had five weeks of recess in two installments since it convened the middle of January, is still in session and is likely to remain so for some time. Comparatively few bills of moment have been advanced beyond the stage of committee assignment. It is impossible, therefore, for this committee, at this time, to render more than a progress report.

We feel that all bills that tend to tear down or to weaken the Medical Practice Act are of more vital concern to the Society and perhaps to the general welfare than other measures proposed in which the profession has a legitimate and natural interest. Bills of this character should enlist our close and steady interest and our strongest opposition. There is no sense or logic in spending years of effort to build and have enacted a strong Medical Practice Act and then permit, through inertia, the passage of bills which sabotage that Act.

There have been introduced at this session of the Legislature five (5) bills which very definitely would adversely affect the Medical Practice Act.

BILLS AFFECTING THE MEDICAL PRACTICE ACT

Assembly No. 4, introduced by Dr. Browne, Mercer County. This bill would repeal in its entirety the Uniform Medical Practice Act enacted in 1939.

Comment.—The introducer of this measure, while a medical man, except for a short period of service in the Medical Reserve Corps during the World War, has never practiced medicine. He has never been a member of organized medicine and his activities have been limited to political and civic affairs. He was a member of the Legislature in 1939, the year of the passage of the Uniform Medical Practice Act. He voted against the passage of the bill but did not speak against it. A conference with Dr. Browne since the introduction of this bill, A. 4, inclines us strongly to the opinion that no further effort will be made by him to advance this measure.

Senate No. 92, introduced by Mr. Stanger, Cumberland County.

Assembly No. 339, introduced by Mr. Boswell, Cape May County.

Comment.—Both of these bills would permit certain individuals, whose educational qualifications are sub-standard (graduates of class C schools), to take the examination for licensure to practice medicine.

Assembly No. 353, introduced by Mr. Boswell, Cape May County. This bill empowers the State Board of Medical Examiners to confer, and makes it mandatory that the Board shall confer, the degree of "Doctor of Medicine and Surgery" on a group of osteopaths (200) who have fulfilled the requirements of two years' post-graduate study and who have successfully passed the examination for full licensure to practice medicine and surgery.

Comment.—This preposterous and grotesque proposal, according to the statement attached to the bill, is premised on the false assumption that those osteopaths who had been granted a full license to practice medicine would be eligible for commission in the Medical Reserve Corps in the event of being drafted for military service, if the degree of "M.D." were conferred upon them by the Board of Medical Examiners. At a personal interview with Mr. Boswell, the introducer of this bill, Dr. Crowe, President of the Cape May County Society, correctly informed him that the conferring of the degree of "M.D." on this group as proposed in this bill would not make them eligible for commission in the Medical Reserve Corps, further informing him that only graduates of class A medical schools are eligible for commission. In response to the request of Mr. Boswell, who stated that if "something official" could be shown him substantiating this contention he would either withdraw the bill or permit it to die in committee, a copy of a letter from the Acting Surgeon-General of the Army, procured through the prompt effort of Dr. Scott, secretary of the Committee on Medical Preparedness, was sent him. This letter from the Surgeon-General quoted the pertinent section of Army regulations which states that only graduates of Class A medical schools are acceptable for commission; and concluded with the statement that the policy and regulations of the War Department would be unaffected by the action of State legislatures. This bill has not been withdrawn but from the information at hand it is believed it will remain in committee.

The responsibility for the introduction of this bill (A. 353) is not chargeable to the New Jersey Osteopathic Society. This Society has gone on record as opposed to the bill; and prior to this action, the keymen of this organization: the President, the Chairman of the Legislative Committee, the former chairman of that committee, and the osteopathic member of the Board of Medical Examiners, unequivocally, by letter and verbally, disclaimed on behalf of themselves and their Society responsibility for its introduction and registered their opposition to its passage. Apparently, a group of osteopaths from the southern part of the state, acting independently, are the sponsors of this reprehensible measure.

Senate No. 156, introduced by Mr. Schroeder, Bergen County. This bill would provide for the granting of a license to practice osteopathy by reciprocity to the holder of such a license from the District of Columbia. And it would further permit the holder of this license, upon the completion of the two (2) year prescribed post-graduate course (now ineffective), to take the examination for licensure to practice medicine and surgery.

Comment.—This bill would affect a former chiropractic member of the Board of Medical Examiners. A license to practice osteopathy was granted by the Board of Medical Examiners to this individual, which was subsequently revoked because the license was issued after the effective date, May 23rd, 1935, prescribed in the Medical Practice Act. This measure is opposed by the osteopaths.

Senate No. 190, introduced by Mr. Stanger, Cumberland County. This bill would create a separate Board of Chiropractic Examiners and "establish standards".

Comment.—This is a replica of one of the hardy perennials which bob up at each session of the Legislature.

All of the above-mentioned bills, with the exception of A. 339 and A. 353, are in the Committee on Public Health of the Senate or House to which they were originally assigned. A. 339 and A. 353 are in the Judiciary Committee of the Assembly. The introducer of these two measures is the chairman of this committee.

CHIROPODY

Assembly No. 60, introduced by Mr. Herbert, Monmouth County.

Assembly No. 257, introduced by Mr. Beers, Warren County.

A. 60 is sponsored by the New Jersey Chiropody Society.

A. 257 is sponsored by The Medical Society of New Jersey.

A. 60. Would create a separate Board of Chiropody Examiners; extend the educational requirements to include two (2) years in a college of Arts or Sciences and four (4) years in a chiropody school; permit almost unlimited privileges in the treatment of any ailment of the foot and leg.

A. 257. Continues the licensing of chiropodists by the Board of Medical Examiners; provides for four (4) years' high school and three (3) years in a chiropody school; defines definitely, though liberally, the scope of practice in the treatment of foot ailments.

Comment.—Both of these bills are in the Committee on Public Health of the Assembly. We have reason to believe that A. 257 (sponsored by the Society) will soon be reported out, perhaps with minor amendments.

WORKMEN'S COMPENSATION

Assembly No. 167, introduced by Mr. Myers, Bergen County. Establishes "reasonable compensation" for treatment of hernia, instead of the present maximum allowance of \$150 for medical and hospital care.

Comment.—This bill, sponsored by the Society, passed the Assembly without opposition April 7th and is now in the Committee on Banking and Insurance of the Senate.

Of the 63 bills thus far introduced having public health implications and medical interest, 45 have been analyzed and the committee's action with respect to these has been: *Approved*, four (4); *disapproved*, eight (8); *action deferred*, two (2); *no action*, twenty-nine (29).

A number of the bills upon which no action was taken appear to have merit, but from our contacts with the Health Officers Association and the State Department of Health we believe these measures will have their support. This committee felt that this year our efforts should center on bills of particular and general concern to the profession.

We have endeavored to improve our contacts with the legislators and to secure a better understanding by them of our legislative objectives. So far this year conferences of the officers, keymen and legislators of the following counties have been held, attended by the Executive Secretary of the Committee: Atlantic, Camden, Essex, Mercer, Ocean and Warren. We are more strongly than ever of the opinion that these conferences are the best single method of effecting improved relations and better understanding between the county society keymen and their legislators.

ACKNOWLEDGMENTS

Again we wish to acknowledge with appreciation the fine coöperation of the Executive

Officer of the Society, Dr. Wilkes, and the excellent assistance of the office manager, Mrs. Madden, and the office personnel. And we would also like to make recognition of the excellent coöperation of the Committee on Public Relations.

Aside from the above report concerning legislation that is in the making, we desire to call attention to the tremendous amount of correspondence that is entailed in connection with the work of the Executive Secretary and which promises, when compared with last year's work, to be tremendously increased this year, and it seems to us that some provision ought to be made to meet this situation. However, this is a matter for the Committee on Finance.

The Chairman personally desires to acknowledge the splendid services rendered by Dr. Fred-eric J. Quigley, the Executive Secretary of our Committee, who by constant and regular attendance at the legislative sessions has obtained the recognition of the Legislators, which has been of incalculable value to our profession. He has been able to intimately contact the

members of the Public Health Committee and by private conferences with these committees has been able to impress them with our views regarding legislation affecting the welfare of organized medicine. Dr. Quigley's conscientious efforts in behalf of the medical profession are hereby gratefully acknowledged.

Finally, I desire to express my grateful appreciation for the cordial coöperation that I have received from the members of the Legislative Committee who at all times have responded to every call that has been made upon them. It has been a privilege to serve with them, and I trust that our combined efforts have met with the approval of the members of The Medical Society of New Jersey.

All of which is respectfully submitted.

BERTHOLD S. POLLAK, *Chairman*
WENDELL J. BURKETT, *Vice-Chairman*
WILLIAM C. WILENTZ
ROBERT E. WATKINS
H. ROY VAN NISS
THOMAS E. MANLY
JOSEPH M. KUDER
THOMAS A. CLAY
CHARLES H. MITCHELL
FREDERIC J. QUIGLEY, *Executive Secretary*
SAMUEL ALEXANDER, *Consultant*

REPORT OF THE SUB-COMMITTEE ON PUBLIC RELATIONS

By CHARLES M. ROBBINS, M.D., Chairman, Newark, N. J

To the Welfare Committee:

Your Public Relations Committee has devoted its year primarily to the cultivation of good community relations and to the promotion of the standing of our profession and our Society in the minds and hearts of the public. We have put relatively little emphasis on health education, since limited personnel, funds and time, made it impossible to do this without neglecting the more pressing problem of community relations. Accordingly we have left the promotion of health education largely to the Advisory Committees and County Societies, except in-so-far as we have made a contribution to that field by supplying speakers and scripts on health topics.

We have established an excellent and effective relationship with the press of New Jersey. Since October 1, our clipping bureau has returned 146 clippings of copy which this Committee has released to the newspapers. This does not count the material on the Medical Service Plan nor the copy on the Annual meeting, none of which had been released at the time of preparation of this report. Each of these 146 news items represents a bit of favor-

able publicity written to make the reader see The Medical Society in a friendly, helpful light. The pacing of these releases was not even, however. During certain periods, as for example, when meetings like the November Clinical Conference or the address by Dr. Frank Lahey, are going on, there is of course much more publicity. The Committee has found that, without exception, every item which it has prepared has secured newspaper recognition. The only limit on the amount of favorable publicity thus available is the amount of material we can collect. If we could have secured the news-worthy findings of the many advisory committees, we could have kept up a steady flow of attention-arresting publicity all year.

Your Committee has placed its facilities at the disposal of the Woman's Auxiliary with results which have been admittedly gratifying to that organization. We have set up a central registry of speeches and scripts from which we have supplied over two dozen doctors who wanted material for addresses to the laity.

Our Speakers' Bureau has had a very active year. We have received dozens of requests for

speakers, and to date have met every assignment. This was sometimes difficult because of short notice, but no organization has appealed to us this year in vain.

We have coöperated with related organizations in the health field, assisting them in their educational programs, and receiving assistance from them. We have, in this way, worked with the Tuberculosis League, the Parent-Teachers Organizations, the Health and Sanitary Association, the New Jersey Welfare Council and similar bodies.

We have provided special publicity for special occasions. During the Fall Clinical Conference we secured a large amount of vivid publicity, much of it pictorial. At the Town Hall on March 24, we were able to present the Medical Society's story in the printed program; and on this occasion, New Jersey's largest Sunday newspaper gave us practically an entire page of publicity. This is probably the largest amount of unpaid space which a New Jersey newspaper has ever given to a private organization.

We have kept the membership alert to the meaning and content of our program by monthly articles in the "Journal", and by frequent releases to the county Bulletins.

In the light of its active and, it is hoped, effective, experience this year, your Committee wishes to make several recommendations for the consideration of the Welfare Committee of the next Administration.

1. It is recommended that the services of the Clipping Bureau, the Press Association, and the paid physician-secretary of the Committee, be continued.

2. It is recommended that some mechanism

be set up for channeling to this Committee the findings of the various advisory committees so that their reports may secure the public attention they deserve.

3. It is recommended that the Speakers' Bureau of the County Societies be integrated with the Speakers' Bureau of The Medical Society of New Jersey, to prevent overlapping of function and to provide for more efficient centralization of work.

4. It is recommended that the Medical Society take even more active part in the activities of the many hygienic, health and welfare groups in our state.

5. It is recommended that the general policies of the 1940-41 Committee be continued.

The Committee is grateful to Dr. Wilkes for his helpfulness and patience in servicing the office details; to Dr. Scott for his cheerful co-operation in preparing copy on Medical Defense and the Medical Service plans; to Dr. Overton and Dr. Barkhorn for their generous allotment of Journal space to the activities of this Committee; to the office force in Trenton which has so diligently turned out the mimeographed copy, so swiftly forwarded the scripts requested, and so efficiently run its behind-the-scenes machinery; and to Dr. Morris who has so energetically carried the Society's message to the public, that he has become our Society's best good-will ambassador.

Respectfully submitted,

CHARLES M. ROBBINS, *Chairman*
G. BARTON BARLOW, *Vice-Chairman*
HENRY A. DAVIDSON, *Secretary*
EDGAR P. CARDWELL
LOUIS K. COLLINS
HAROLD D. BARNSHAW
AUGUST H. GROESCHEL
ROYAL A. SCHAAF
J. EDWIN OBERT
RALPH M. L. BUCHANAN
GEORGE W. FITHIAN, *Consultant*

REPORT OF THE SUB-COMMITTEE ON MEDICAL PRACTICE

By REUBEN L. SHARP, M.D., Chairman, Camden, N. J.

To the Welfare Committee:

The Advisory Committees to the Medical Practice Committee have carried out their programs as outlined at the beginning of the year. In addition to handling the problems which have been referred to them, some of the committees have been particularly active, and especial attention is called to the report of the Committee on Hospital Relationships, the Committee on Auxiliary Medical Services and the Committee on Pharmaceutical Problems.

We are grateful to all of the Advisory Committee members for their efforts and contributions. Some of the work of the committees is still incomplete, but the work of these committees will, at the end of any given adminis-

trative year, always be incomplete. The status of organized medicine has not greatly changed in the past year, but we have endeavored to look ahead and be prepared to meet whatever changes occur, as a result of changes in the economic status of the people of this country.

Respectfully submitted,

REUBEN L. SHARP, *Chairman*
HENRY B. DECKER, *Vice-Chairman*
SIGURD W. JOHNSON
CHESTER I. ULMER
SAMUEL BARBASH
JAMES M. CARLISLE
WILLIAM K. HARRYMAN
A. CHARLES ZEHNDER
ANDREW C. RUOFF
HERSCHEL S. MURPHY
THOMAS K. LEWIS, *Consultant*

REPORT OF THE ADVISORY COMMITTEE ON AUXILIARY MEDICAL SERVICES

By SIGURD W. JOHNSEN, M.D., Chairman, Passaic, N. J.

To the Sub-Committee on Medical Practice:

A. The work of the Advisory Committee on Auxiliary Medical Services for the year of 1941 has been a continuation of the splendid work of the preceding years.

Following the adoption of the organization set-ups approved by the State Society at its last Annual Meeting, the Committee has attempted to give as wide publicity as possible to these organization plans. These include standard set-ups for the following departments in general hospitals of 200 beds and under:

Clinical Pathological Laboratory
Department of Anesthesiology
Physical Therapy Department
Radiological Department

Reprints of the complete report have been forwarded to the following:

Secretary and President of the New Jersey Radiological Society.
New Jersey Society of Physio-Therapy Physicians.
American Congress of Physical Therapy.
New Jersey Society of Clinical Pathologists.
Secretaries of all State Medical Societies.
American Medical Association.
American College of Surgeons.
American College of Physicians.
President of the New Jersey Hospital Association.
President of the National Hospital Association.
President of the Hospital Insurance Boards.
President and Secretaries of Boards of Governors, or Trustees of each hospital in New Jersey.

Comments received so far, have all been favorable regarding the suggested organization on set-ups.

B. The action of the Newark School Board in purchasing and setting up Radiological Apparatus for the examination of school children, without the supervision and direction of a competent radiologist has been disapproved, and a letter to the Board to this effect has been sent by our Executive Secretary, Dr. Wilkes.

C. The request of the Selective Service Administration for a fee schedule of laboratory and x-ray charges done in connection with the physical examination of selectees was disap-

proved. The Committee recommends that the services rendered by the clinical pathologists and radiologists to the Medical Preparedness Program be compensated for, on a reasonable basis.

D. The Committee endorses wholeheartedly the plan of the Medical Service Administration. It wishes to call attention to the Board of Trustees, that there is a definite cost basis for "Services Rendered" by the physicians represented in the specialties of the Auxiliary Medical Services. It further recommends that the Trustees in allocating remuneration to these physicians for such services bear this cost basis in mind.

E. The Committee recommends that the following resolutions passed by the Board of Regents of the American College of Surgeons, regarding the financial relations between physicians and patients in hospital practice, be enforced in the hospitals of New Jersey:

1. Each doctor who participates in the care of a patient is entitled to compensation from the patient commensurate with the services rendered.

2. Whenever practicable and possible the attending physician should acquaint his patient with his financial responsibility to those concerned with his care.

3. Each doctor concerned in the care of a patient should give or send directly to the patient a detailed statement showing charges for professional services rendered.

4. Combined statements should be avoided as they may constitute subterfuges for fee-splitting.

5. Each doctor who participates in the care of the patient should send a personal receipt directly to the patient for all moneys received from the patient or other legitimate or authorized source.

6. In-so-far as possible, a third person should not enter into the financial relations between doctor and patient, and to this end hospitals should be discouraged from determining or collecting fees for doctors.

7. An exception to the foregoing principles must, of necessity, be made when there is a formally organized clinic or legal partnership which in effect may be regarded as an individual and which acts in that capacity. This principle should apply also when the clinic and hospital are combined and under the same ownership.

F. A resolution has been adopted by the Committee requesting that our State Society request the New Jersey Hospital Association to appoint a committee to meet and to coöperate with the Advisory Committee on Auxiliary Medical Services in furthering better relationships in hospitals and the Auxiliary Medi-

cal Services in the various hospitals of the State of New Jersey.

Respectfully submitted,

SIGURD W. JOHNSEN, *Chairman*
ARTURO R. CASILLI, *Vice-Chairman*
EUGENE G. HERBENER
WALTER A. TAYLOR
JEROME H. SAMUEL
W. JAMES MARQUIS
ASHER YAGUDA
ALFRED STAHL, *Consultant*

REPORT OF THE ADVISORY COMMITTEE ON CONTRACT PRACTICE

By ANDREW C. RUOFF, M.D., Chairman, Union City, N. J.

To the Sub-Committee on Medical Practice:

As Chairman of the Advisory Committee on Contract Practice, I wish to report that nothing was presented to this Committee during the past year that required our attention. I attended several meetings of the Welfare Committee and took part in the discussions of that

committee, as they affected the welfare of the Society.

Respectfully submitted,

ANDREW C. RUOFF, *Chairman*
HARVEY T. HEROLD
HENRY HAYWOOD
EDWARD F. KLEIN
J. HOWARD HORNBERGER, *Consultant*

REPORT OF THE ADVISORY COMMITTEE ON HOSPITAL RELATIONSHIPS

By HENRY B. DECKER, M.D., Chairman, Camden, N. J.

To the Sub-Committee on Medical Practice:

The Hospital Relationships Committee has completed the survey of the Out-Patient Department of Cooper Hospital that was planned and initiated in 1940. A preliminary report on this survey was made to the House of Delegates in November, 1940.

Considerable data as to technique and method in conducting such a survey was acquired. A survey of out-patient departments throughout the State, in coöperation with the New Jersey Hospital Association, the Department of Institutions and Agencies, and the Works Progress Administration was planned. After authorization by the Board of Trustees, a formal application for a W. P. A. grant was made. This application has not yet been acted upon by the authorities in Washington. Hence further effort in extending the survey has been held up until such times as action is taken by the W. P. A.

This data was tabulated and analyzed by Dr. Emil A. Frankel, Statistician of the Department of Institutions and Agencies. The report was published by the State Society and copies distributed to the delegates.

DEDUCTIONS

In examining the survey, certain facts are evident. The first and most important is that the O. P. D. and its staff are serving the community as a consultation center.

The original plan was to establish free dispensaries as a central place for the treatment of indigent sick. During the past few years, coincident with the advances made in medical knowledge and techniques, and the more adequate accumulation of costly apparatus in hospitals, available for the use of the specially trained physicians on their staffs, the original purpose of the free dispensary has become submerged.

PROCEDURE

The data of the Cooper Hospital Survey was collected by a committee of the Staff, Superintendent, and the Social Service Department.*

* Miss Emily Y. Smythe, Director of Social Service.

RECOMMENDATION

This might be an appropriate time for the House of Delegates to call to the attention of hospital authorities that such changes have occurred, and that the O. P. D. of a hospital

should now be reorganized with the thought of furnishing a consulting service to the physicians attending the low or medium wage groups. From our experience with this survey such a plan could be worked out at possibly a saving to the hospital and certainly a saving of time and effort to the staff.

In further examining the survey it was found that abuse of the dispensary by patients financially able to pay was at a minimum. Something over 60 per cent of the new patients were referred to the O. P. D. by their doctor.

It was felt that the O. P. D. should serve as a training school for physicians in practice. The present plan of appointment is for a younger man to accept an assistantship in a certain department. Thereafter he remains in that department for years. Younger men who are qualifying in the particular specialty pass over him if he decides to continue in the general practice of medicine. This tends to result in irritation, dissatisfaction, and a lowering in the quality of work.

This might also be a proper time to call attention to the fact that the general practitioner of medicine is the most numerous and most important individual in a medical service, and that no systematic plan for his training, after internship, has been developed. It might be well to consider two types of appointments to our staffs:

1. The Specialist—which is held by a man qualifying in that particular branch of medicine.

2. The General—held by the man who desires to remain in the general practice of medicine. This appointment to be so arranged that the holder rotates through the various departments of the O. P. D. and thus acquires training and skill in all of the various specialties. This rotation would have to be arranged by an appropriate committee of the Hospital Staff and all members of the staff should cooperate.

It is not essential that the hospital should be a so-called "teaching hospital". The staff of any hospital that trains internes has sufficient teaching ability to do this.

It is possible that with the approval of the House of Delegates some arrangement might be made with Rutgers University, whereby the physician completing such a planned rotation and preparing a suitable thesis, might be given a Master's or Doctor's degree.

The committee plans to continue this survey of other O. P. D.'s whether the W. P. A. grant is made or not.

Respectfully submitted,

HENRY B. DECKER, *Chairman*
SPENCER T. SNEDECOR, *Vice-Chairman*
GEORGE O'HANLON
CHARLES HYMAN
EARL H. SNAVELY
JAMES H. SPENCER, JR.
EDWARD A. Y. SCHELLENGER
THOMAS K. LEWIS, *Consultant*

REPORT OF THE ADVISORY COMMITTEE ON INDUSTRIAL HEALTH AND HYGIENE

By J. MALLORY CARLISLE, M.D., Chairman, Westfield, N. J.

To the Sub-Committee on Medical Practice:

The Advisory Committee on Industrial Health and Hygiene, in presenting a review of the work done by this committee during the 1940-41 administrative year, wishes to acknowledge its indebtedness and appreciation to Dr. J. Irving Fort and his committee for the splendid program outlined, which has provided the basis for the continuation of the work of this committee. Dr. Fort's committee suggested an approach to the solution of some of the current problems in the conservation of the industrial worker's health, and our endeavors have been to carry further this approach and amplify, out of any increased knowledge and experience gained, the proposals already made.

Your Chairman, with the help of the members of the committee, has endeavored to orient

himself in the preceding efforts of this committee, so that the present committee's program might be effectively integrated, not only with the other committees of The Medical Society of New Jersey whose work touches the health of the industrial worker, but also with all other state agencies whose activities contribute to this same purpose.

Since National Defense is now the first item of business on America's agenda, and since such defense calls for the highest efficiency in the worker, as well as in the machine, it is evident that the health of the worker is essential to insure the health and safety of our nation, and all physicians must lend every effort to help maintain the health of our industrial personnel.

The larger industries have found by actual experience that the money invested in their

well-organized programs of health supervision, conducted under especially trained and experienced physicians and their co-workers, paid in demonstrable benefits to the workmen and to the company. In the future this will be further evidenced as a benefit to the nation.

The smaller industries, with 500 or less employees, need further education and demonstration in protection of the health of the workers in order to provide conviction as to the economy as well as the effectiveness of high grade medical supervision and care. The pressing demands of our defense program will bring about a demand that the workers in these industries receive proper care, and, with the example set by the larger industries through plans and activities carefully worked out and proven to be economical and effective, a solution of the problems of these smaller industrial groups should be quickly reached.

The Advisory Committee on Industrial Health and Hygiene of The Medical Society of New Jersey will do its full part in conjunction with its colleagues specializing in this field and with organizations such as the New Jersey Association of Industrial Physicians, the New Jersey Association of Industrial Nurses, and other state or national agencies and organizations we may enlist in our endeavor to improve the health of the industrial workers of these smaller concerns where the management, by voluntary action, may prefer in this way to avoid what might otherwise be an inevitable governmental interference and control for this purpose. Such improvements seem inevitable and may come quickly. The primary concern of industry and medicine at this time is that such change shall come through *evolution* and as the result of effective provision, jointly worked out through these groups, thus avoiding revolutionary changes which might result through government control and regulation of industrial health made possible by United States Senate Bills 193 and 509.

The time is ripe and the need is urgent for a real exploration, made through proper channels and under proper supervision, to determine the possibilities of utilizing effectively and economically unexpended funds now available under Title 6 of the Social Security Act. The United States Public Health Service has obtained a deficiency appropriation for the balance of the current fiscal year, and it is likely that with the addition of the regular appropriation for 1942 the Division of Industrial Hygiene under the direction of Dr. J. G. Townsend, Medical Director and Chief, with his able Sanitary Engineer, J. J. Bloomfield,

who is active, competent and coöperative, will lend every assistance to state programs.

Your committee has had representatives at the following meetings:

1. Attendance at the January 14 to 18 Third Annual American Medical Association Conference on Industrial Health, at which time discussions were held with many of the representatives from the different states who appeared to have been most active in publishing and presenting the reports of their various state organizations and agencies in the field of industrial health and hygiene.

2. Attendance and coöperation during the executive meetings of the above conference at which time your Committee reported on the industrial health activities within our state.

3. Three visits to the executive offices of the American Medical Association at 535 North Dearborn Street, Chicago, for the purpose of discussion with Dr. Carl M. Peterson, Secretary of the Council on Industrial Health, the industrial health problems current within our state as well as the practical application of much of the knowledge and information gained during the above Third Annual Conference.

Your committee would like to acknowledge the great help and many services, as well as the splendid coöperation and support tendered us by Dr. Peterson, who is thoroughly and satisfactorily handling his part of this most important but difficult national problem.

4. Conference with executive representatives of the Wisconsin State Medical Society, and in particular discussions concerning the functioning of the "Wisconsin Plan".

5. Visits for the purpose of studying the industrial hygiene activities in the large and small industrial units and divisions in and around Chicago, Illinois; Madison, Wisconsin; Rochester, St. Paul, and Minneapolis, Minnesota; St. Louis, Missouri; as well as various industrial units in the states of Delaware, Pennsylvania and New Jersey.

6. Conferences with the executive directors as well as members of the New Jersey Association of Industrial Physicians. This group of physicians, whose interests and activities are demonstrably in the field of industrial medicine, and who, for the most part, devote their full time to the practice of medicine, and particularly preventive medicine, in industry, represent many of the large and some of the small industries within our state. The preventive medicine activities of these industries might well be emulated by many of the larger industries now without adequate medical services, as well as the smaller industries which

for the most part are giving insufficient attention to their problems of industrial health.

7. Guest attendance at the Fourth Annual Meeting of the National Conference of Governmental Industrial Hygienists, February 17-18, 1941, Washington, D. C., at which time a four-point industrial hygiene program in national defense was unanimously adopted. The four points of this program are:

1. Training of industrial hygiene personnel.
2. Services to Governmental arsenals and navy yards.
3. Field and laboratory investigations.
4. Assistance to State industrial hygiene units in their programs for—
 - a. Investigation and control of hazards.
 - b. Advice on plant construction and renovation.
 - c. Promotion of health examinations and medical care.
 - d. Education.
 - e. Promotion of adult hygiene programs.

The Federal, State, and local industrial hygiene bureaus will cooperate in carrying out this program.

8. Conferences with the New Jersey Industrial Nurses' Association. Physicians familiar with the current problems of industrial health within our state were supplied as speakers for the Third Joint Conference of the New England, New York, New Jersey, and Philadelphia Industrial Nurses' Association, held under the auspices of the New Jersey Industrial Nurses' Association. Your Committee acknowledges the help and cooperation from our industrial nurses, who should play a great part in achieving the objectives of industrial health within our state.

9. Conferences with the executive directors of the New Jersey Health and Sanitary Association. This group now has a Committee on Industrial Hygiene which is working closely with your Committee on Industrial Health and Hygiene. Their help and cooperation is needed and their activities to date seem assurance that similar harmonious relations may be expected in the future.

10. Discussions with executive members of the American Conference on Industrial Health, who offer the facilities of their organization for the advancement of industrial health in our state.

11. Conferences with several of the cooperative organizations of our Society, as well as with various groups within our Society for the purpose of discussing and correlating our

various activities so that duplication of effort may be minimized and the desired objectives of this Committee reached with greatest ease and dispatch.

12. Conferences with the New Jersey Public Health Association as well as the New Jersey Department of Labor in an effort to foster and promote mutual understanding and cooperation.

13. Informative and cooperative talks with industrial groups (lay, professional, and scientific) throughout the state, which have apparently been well received and duly recognized.

14. Cooperation with the New Jersey Social Hygiene Conference in response to their request that we supply speakers for their Third Annual Conference. It was requested that the speakers discuss the activities of our Committee in fostering preventive medicine in industry, with especial emphasis on the safeguarding and preserving of health and strength in our defense industries.

15. Many of the County Society Committees on Industrial Health and Hygiene have done splendid work. Their cooperation and constructive activities are to be regarded as significant contributions in the field of industrial medicine.

With the information gathered at these meetings, and at every other opportunity which presented itself, the Committee is planning intensively, and hopes in the ensuing year to offer a program for the education and intriguing of the interest of the private practitioner and all other physicians interested and engaged in any form of service to the industrial worker. This program will divide naturally into the three categories listed below:

1. Progress reports, which we hope will appear in the New Jersey State Medical Journal.
2. Stimulation of interest in industrial health and hygiene by various ways and means through the cooperative and collaborative endeavors of various agencies.
3. Lectures, talks, and demonstrations at State and County Society meetings, hospital staff meetings, and scientific meetings held under the auspices of the Counties, as well as those in the plant health departments of several industrial organizations throughout the state.

Respectfully submitted,

J. MALLORY CARLISLE, *Chairman*
LESLIE E. MYATT, *Vice-Chairman*
CEDRIC C. CARPENTER
H. IRVING DUNN
DONALD O. HAMBLIN
J. F. NORTON, *Consultant*

REPORT OF THE ADVISORY COMMITTEE ON THE MEDICAL CARE OF THE INDIGENT AND LOW-WAGE GROUP

By HERSCHEL S. MURPHY, M.D., Chairman, Roselle, N. J.

To the Sub-Committee on Medical Practice:

Our Committee felt that our program for the year could be divided into two parts: First, to coöperate with the plan of the Medical Service Administration of New Jersey in caring for the low-wage group; second, to coöperate with the State authorities in helping to carry out the State plan for the medical and hospital care of the indigent. It seemed to us that if we could serve as an advisory committee with Mr. Charles R. Erdman, Jr., Director of Municipal Aid Administration of the State of New Jersey, in the care of the indigent, our efforts would be well directed.

Our Committee held a meeting last October with Mr. Erdman and Mr. Arthur Mudd, the Deputy Director, to discuss ways of putting into effect the State Plan for the Medical and Hospital Care of the Poor. This plan unfortunately is dependant upon voluntary coöperation of the municipalities. During the Winter it was seen that it was almost impossible to get all the municipalities to coöperate due to various local conditions. Hence, it was decided that if legislation could be enacted by the State Legislature authorizing the Director of Municipal Aid to promulgate such rules and regulations as might be necessary to put the plan in operation on a State-wide basis in all municipalities, this would be the ideal arrangement.

In February, 1941, a bill was introduced into the Senate labelled "An Act Concerning the Administration of Relief" which would carry out the above purposes. At the present time this bill has not yet been passed. So in regard to this matter we report progress.

Dr. Watson B. Morris, our President, also

appointed our Committee as the representative of the Medical Society in connection with the study of facilities for the care of the chronically ill in New Jersey. This study is being made by the New Jersey Department of Institutions and Agencies together with representatives of the New Jersey Hospital Association, the State Department of Health, the State Organization for Public Health Nursing, the Director of Municipal Aid Administration, a representative of the State Board of Control of the Department of Institutions and Agencies and a representative of The Medical Society of New Jersey. Dr. Ellen C. Potter of the Department of Institutions and Agencies is serving as Chairman of the group. This survey covers the Homes for the Aged, Nursing Homes, General Hospitals and Special Institutions. While the survey is not complete, the present census shows an increase of nearly a thousand persons more in nursing homes now than was the case in 1936. Since the age-level of the people of this State is gradually increasing, it can be seen that careful planning must be made to take care of the increased needs in the future.

We feel that while a great deal has been done this year and much of the groundwork has been laid, there still is much to be done during the next few years.

Respectfully submitted,

HERSCHEL S. MURPHY, *Chairman*
DAVID W. GREEN, *Vice-Chairman*
D. LEO HAGGERTY
FRANK L. FIELD
WILBUR WATTS
THOMAS A. CLAY
BYRON G. SHERMAN
EDWARD J. CALLAHAN
GEORGE W. FITHIAN, *Consultant*

REPORT OF THE ADVISORY COMMITTEE ON NURSING AND NURSING EDUCATION

By A. CHARLES ZEHNDER, M.D., Chairman, Newark, N. J.

To the Sub-Committee on Medical Practice:

During the past year the relations between the Nursing Association and The Medical Society of New Jersey have been most cordial. There have been no major problems engaging the attention of our Society with the Nursing Associations. Neither have there been any minor problems for this Committee to consider

or solve, therefore this Committee did not find it necessary to be very active during the present year.

Respectfully submitted,

A. CHARLES ZEHNDER, *Chairman*
GEORGE M. KNOWLES, *Vice-Chairman*
H. WESLEY JACK
VICTOR KNAPP
HARRY SUBIN
DAVID W. GREEN, *Consultant*

REPORT OF THE ADVISORY COMMITTEE ON PHARMACEUTICAL PROBLEMS

By CHESTER I. ULMER, M.D., Chairman, Gibbstown, N. J.

To the Sub-Committee on Medical Practice:

Our Committee's chief endeavor during the past year has been the publication of the new fourth edition of the New Jersey Formulary. This is a joint accomplishment with a committee from the New Jersey Pharmaceutical Association. The Formulary has already gone to press on the date this report is being written (March 25, 1941). It will be improved over the previous editions, containing new formulas and material.

It is gratifying to note that this compend of formulas has become useful and popular with many physicians in the State. Copies of the new edition will be sent to every member of the State Society, to internes in New Jersey hospitals and also to hospital pharmacies.

Pharmacists all over the State report that physicians are making good use of the Formulary. Prescriptions indicate that more ethical formulas are being written and that there is less proprietary prescribing.

PROPOSED LEGISLATION

In March, certain pharmaceutical interests in the State proposed an amendment to the Food, Drug and Cosmetic Act which would require additional recording of drugs dispensed by physicians. This amendment would require physicians who dispense drugs to keep a record of the name of the drug, the quantity dispensed, and the name and address of the

patient, and would also require the dispensing physician to label such drugs with a serial number, date and name and office address of the physician.

Our committee met on March 16, 1941, to consider the proposed amendment. It was opposed because most physicians already keep a record of any drugs they dispense to patients. This is routinely done on the history card of each patient. Physicians also label dispensed drugs. The committee thought that it might be advisable to present the matter to the House of Delegates at the annual meeting in May when a greater number of physicians could express an opinion since there was no apparent emergency for immediate action.

The committee expressed the hope that no legislation would be attempted that might disturb the present cordial relations of the pharmaceutical and medical professions in the State, and that nothing would occur that might discourage the broad, constructive program now in progress by the Joint Committee on Professional Relations of the New Jersey Pharmaceutical Association and The Medical Society of New Jersey.

Respectfully submitted,

CHESTER I. ULMER, *Chairman*
REEVE L. BALLINGER
JACOB J. MANN
IRVING OKIN
DANIEL W. TELLER
RALPH K. HOLLINSHED, *Consultant*

REPORT OF THE ADVISORY COMMITTEE ON WORKMEN'S COMPENSATION

By WILLIAM K. HARRYMAN, M.D., Chairman, Hackensack, N. J.

To the Sub-Committee on Medical Practice:

The Advisory Committee on Workmen's Compensation wishes to report that they have accomplished what they feel is a fairly satisfactory amount of work for this year.

A meeting of the entire committee was held in November, 1940, at the Newark Athletic Club, as the guests of the President, Dr. Watson B. Morris. In addition to the committee members there were present representatives of the labor unions as well as one of the Deputy Commissioners of the Department of Labor.

It was decided that before the end of this year that we would attempt to amend the pres-

ent bill on compensable hernias so as to eliminate the question of specified fees. The bill now allows a fee of \$150.00 to cover all medical expenses. We felt that it would be more fair to treat a hernia on the merits of the case in the same manner as any other surgical procedure.

We also decided that if Labor had any bills they wished to introduce this year in regard to occupational disease that we would be very glad to go along with them if they would allow us to review the proposed bills and advise them from the medical standpoint. So far no such bill has been presented to us.

It was also decided to prepare a brief booklet for distribution to all the members of The Medical Society of New Jersey with some general advice in regard to handling compensation cases and review of the salient points of the compensation law as regards the medical profession. This is being prepared for distribution at the present time and will also appear in one of the early numbers of the State Journal.

A meeting was also held with Dr. Frederic J. Quigley and several representatives of one of the large employer groups who promised to go along with us on the amending of the hernia act as well as being willing to coöperate in passing any bills referable to occupational disease that were directly applicable to occupations found in New Jersey.

While our original program contained a total of ten objectives we have definitely accomplished the above three, namely, the change in the hernia act, coöperation with labor in passing upon suitable bills referable to occupational diseases and in issuing the descriptive booklet on the compensation law.

The coöperation of all members of the Workmen's Compensation Committee has been most satisfactory.

Respectfully submitted,

WILLIAM K. HARRYMAN, *Chairman*
JOSEPH F. LONDRIGAN, *Vice-Chairman*
EDWIN R. RISTINE
CLARENCE W. WAY
DANIEL F. FEATHERSTON
HENRY H. KESSLER
ANDREW F. MCBRIDE, *Consultant*
STEPHEN LORENZ, *Technical Adviser*

ANNUAL REPORT OF THE SUB-COMMITTEE ON PUBLIC HEALTH

By STANLEY NICHOLS, M.D., Chairman, Long Branch, N. J.

To the Welfare Committee:

Our Public Health Committee and its eleven Advisory Committees have continued to work wholeheartedly during the past year with all State, Public and Private Health Agencies, for the improvement of the health of citizens of New Jersey.

The increased participation of the United States in the world-wide defense of Democracy and Liberty, as we have known it, has added special responsibilities to all of our committees, particularly those concerned with the health of those called to military service.

The coming year will undoubtedly increase those strains and challenge our entire membership to make increasing contributions to the improvement of Public Health of the people of this State. We are confident as this committee now completes ten years of service to the Society that we have, within the Society, an adequate Public Health organization, and the will of every member to do our full share in the preservation of Democracy.

The participation of our members in Public Health problems is complemented by the members of our Advisory Committee and integration of effort promoted through advice given by our Technical Advisers who meet regularly with our Public Health Committee. These advisers are able and responsible representatives appointed by such agencies as the State Department of Health, Education, Institutions

and Agencies, and Labor, and the unofficial state organizations representing dentists, nurses, pharmacists, health officers, and our colleagues in the New Jersey State Medical Association. Thus, the Public Health Committee considers all health problems, even the special ones covered by our Advisory Committees on Child Health, Maternal Welfare, Adult Health, Cancer, Pneumonia and Tuberculosis; also the problems involving Conservation of Vision, Crippled Children, Mental Hygiene, Venereal Disease and Traffic Accidents, from angles presented by representatives of these professional organizations and the State Departments, responsible for health and welfare problems in New Jersey. This coöperative arrangement in New Jersey has resulted in progress through the years, and it is an accomplishment of which The Medical Society of New Jersey may well be proud. The foundation laid during the past ten years, through the participation of the hundreds of members of our State and County Committeemen, has been such that as Public Health problems arise in the State the coöperation of The Medical Society of New Jersey is sought by public and private health agencies. This is a splendid tribute to the medical profession of this State, and we earnestly hope that any National Health Plan now in the making will be of such a nature as to make it possible to continue and develop further, in New Jersey, this type of coöperative Public Health effort.

It is with regret we report the passing of Allen Ireland. Dr. Ireland was a valued veteran of this committee. His earnestness, counsel and wisdom concerning school health will be missed by our committee.

Our eleven Advisory Committees have reported on their activities. For purposes of brevity these reports are condensed. As Chairman, I wish to offer my thanks to the faithful members of the Committee, of the Advisory Committees, the Officers, and other committees of the State Society; the representatives from the Public and Private Health Agencies and the professional organizations of this State for the coöperation which they have given in our many activities during the past year. The most encouraging element is the good will with which all Health and Welfare Agencies approach health problems and work out joint solutions thereof. We hope that the same approach may develop in the national health picture, now marred by evidences of conflict, suspicion, and undue ambition, which have repercussions in our own State.

The inescapable conclusion is that as a part of National Defense definite national plans for expansion of Public Health facilities and wider provision for adequate medical care are now being developed and will soon be completed. These may drastically affect the public and private practices of medicine, and our present procedure in participation in public care. This committee therefore recommends:

Recommendation No. 1.—That we should focus the attention and activities of the Officers and Trustees of The Medical Society of New Jersey, the Welfare Committee and its four Sub-Committees; their Advisory Committees; the County Societies and each of their individual members, on the making of definite plans, well publicized in conjunction with the other health, professional, and welfare agencies of this State, which will meet all challenges during the coming year, Federal and State, to "widen opportunities for adequate medical care" for New Jersey's citizens; and, after careful study to participate in such needed expansion of Public Health facilities as are found necessary for adequate National Defense.

Recommendation No. 2.—That The Medical

Society of New Jersey and its members shall continue to provide their services, collectively and individually, for the preservation and maintenance of the best possible *quality* of medical service, preventive medicine and health promotion for both the military and civilian population of this State.

Recommendation No. 3.—That The Medical Society of New Jersey shall seriously and continuously study all proposed changes in Public Health and medical care as they take form, in the year to come, with particular reference to the *quality* of medical service likely to develop in each proposed form. The Society should study efforts, which will undoubtedly be made by some groups, to draft all health professions for wholesale but inferior health care, which are certain to result in consequent deterioration in the *quality* of this care. In the year ahead, we must be eternally vigilant and ready to make the necessary personal sacrifices to meet all essential health needs. At the same time, we should strive to preserve our present medical liberty, as both public and private practitioners of medicine. In this way alone can we maintain the essential factors which go to make up good *quality* medical service.

Recommendation No. 4.—That The Medical Society of New Jersey shall publicize far and wide our high resolve that we enlist the services of the members of this Society for all essential health developments, necessary for adequate National Defense, and that we continue to aid, as in the past, in the maintenance of the best possible *quality* of public and private health services in New Jersey, developed by thoroughly democratic methods of public procedure.

Respectfully submitted,

STANLEY NICHOLS, *Chairman*
FREDERIC W. LATHROP, *Vice-Chairman*
ABRAHAM E. JAFFIN
ARTHUR W. BINGHAM
EDGAR A. ILL
JULIUS LEVY
ELBERT S. SHERMAN
C. BYRON BLAISDELL
FREDERICK G. DILGER
ELMER P. WEIGEL
JOSEPH E. RAYCROFT
THOMAS M. KAIN
MILLARD F. SEWALL
CHESTER R. BROWN
WILLIAM H. VARNEY
ALDRICH C. CROWE, *Consultant*
ROBERT P. FISCHELIS, *Phar. D., Technical Adviser*
MARGARET ASHMUN, *R.N., Technical Adviser*
WALTER G. ALEXANDER, *M.D., Technical Adviser*
J. M. WISAN, *D.D.S., Technical Adviser*

REPORT OF THE ADVISORY COMMITTEE ON ADULT HEALTH SUPERVISION

By WILLIAM H. VARNEY, M.D., Chairman, Washington, N. J.

To the Sub-Committee on Public Health:

The Sub-Committee on Adult Health Supervision has continued the work of this committee of the previous year, and has emphasized the importance of the periodic health examination through advertisements in *The Journal*, through offering the health examination blanks to physicians of the State, and through an editorial in *The Journal* as well as by means of letters to the secretaries of the various component societies, urging the members to encourage the periodic health examination. The leaflet entitled "Key to Long Life", prepared by this committee last year, was advertised and offered to the members of this profession.

As a means of helping the cause of national defense, it was proposed that this committee undertake the study of possible improvements in the public health by means of improving the nutritional standards of children. With this end in view, an investigation was made of the amount of instruction in nutrition which the students in our high schools receive, with the result that the committee made the following recommendation to the Public Health Committee:

1. "That The Medical Society of New Jersey seek the coöperation of the New Jersey School Physicians Association in bringing a program of nutritional education to the various Parent-Teachers Associations in the state.

2. "That The Medical Society of New Jersey urge the Department of Education to intensify the formal instruction of nutrition to high school students."

It was the opinion of this committee that there is a great need in this state for public hospitals for the care and treatment of chronic diseases, including heart disease and cancer, and

while it was realized that this is a tremendous problem with wide ramifications, it was felt that an initial step in that direction could well be taken at this time. Therefore, the following recommendation was made to the Public Health Committee:

"That The Medical Society of New Jersey go on record as favoring the establishment of hospitals throughout the state for the treatment of chronic disease, including heart disease and cancer."

In January of this year, the chairman of this committee conferred with the directors of Montclair Neighborhood Center of Montclair, New Jersey, regarding the desire of that group to establish a free health examination clinic for indigent people without making any attempt to treat disease. It was thought that such a clinic could, by conducting routine physical examinations of well people, detect certain diseases very early, when they could be more advantageously treated. Such a clinic would not conflict in any way with existing hospitals or clinics which are primarily concerned with sick people, and could serve as a valuable source for collecting interesting statistics for study, should similar clinics be contemplated in the future.

It was therefore recommended that the Medical Society endorse this clinic, provided it be conducted under the supervision of the County Medical Society.

Respectfully submitted,

W. H. VARNEY, *Chairman*
R. K. HOLLINSHED, *Adviser*
F. R. MEYERS
IVAN SMITH
H. A. KAZMANN
GEORGE McDONNELL
E. C. KLEIN, JR.
L. C. HUMMEL
RALPH K. HOLLINSHED, *Consultant*

REPORT OF THE ADVISORY COMMITTEE ON CANCER CONTROL

By EDGAR A. ILL, M.D., Chairman, Newark, N. J.

To the Sub-Committee on Public Health:

The Cancer Advisory Committee approved the report of the Cancer Advisory Committee of 1939-40 as adopted by the New Jersey State Medical Society at its meeting in June, 1940.

The first meeting was held on October 25, 1940, and ten members of the committee were

present. The meeting was opened by a statement by Dr. Morris, President of the New Jersey State Medical Society, to the effect that he thought this committee should decide on something definite to do regarding the control of cancer and the establishment of a cancer clinic and to publicize same in the *Journal*.

INCREASE IN CASES

It was brought out by the Chairman that there is a very definite increase in cancer deaths in the State of New Jersey as shown by the reports of the Bureau of Vital Statistics at Trenton and also by reports of the insurance companies, namely the Prudential and Mutual Benefit Life Insurance Companies. There is no doubt that cancer occupies place No. 2 as the cause of death.

REPORTING CASES

The committee discussed widely and carefully the question of registration of all cancer cases in the State of New Jersey, through hospital registration that is by the pathologist and individual doctor's registration. It was also agreed and moved and passed that this registration be in the form of a confidential report rather than a public report. The motion was passed by the committee as follows:

Motion No. 1. Dr. William O. Wuester, of Elizabeth: "I make a motion that this committee go on record as favoring registration of all cancer cases possible, in the State of New Jersey, through hospital registration and individual doctor's registration."

Dr. L. S. Snegireff, of Trenton: "I add that this registration be in the form of a confidential report, rather than a public report, and that an envelope should be included with each report, and be forwarded to a central agency."

All voted in favor, and it was so ordered by the Chairman.

Motion No. 2. Dr. L. S. Snegireff, of Trenton: "Since the cancer death rate is increasing and since there is a special interest to find out the reasons for such increase, this committee goes on record as favoring compulsory registration of all cancer cases in the form of confidential reports to the State Health Department for the purpose of follow-up of statistical research."

This motion was seconded and all voted in favor and it was so ordered by the Chairman.

Motion No. 3. Dr. W. G. Herrman, of Asbury Park: "I move that this committee be in favor of setting in motion a form or method of lay education, through the use of prepared or individual talks by the Speakers' Bureau of each County Society, and that our State Board of Health help to organize in each county lay groups of those interested in cancer, to secure invitations for these county speakers, and that the Women's Auxiliary be asked to secure invitations for these speakers."

This motion was seconded and all voted in favor, and it was so ordered by the Chairman.

Motion No. 4. Dr. W. G. Herrman, of Asbury Park: "I make a motion that we request the official representatives of both organizations (Curie Institute and the New Jersey Branch of the American Society for the Control of Cancer) to furnish us in black and white the following:

"1. Just what they propose to do in the State of New Jersey.

"2. How are they going to go about it.

"3. A financial statement of the funds collected in the State of New Jersey during the past two years and a balance sheet showing what was done with the money."

This motion was seconded and all voted in favor and it was so ordered by the Chairman.

Motion No. 5. Dr. L. S. Snegireff, of Trenton: "I make a motion to appoint a small group from the members of this committee to work out a form or report card for the first motion."

This motion was seconded and all voted in favor, and it was so ordered by the Chairman.

The second meeting was on November 22, 1940. Eight members were present. The meeting was called at the request of Dr. Hilton S. Read, Chairman of the Welfare Committee of The New Jersey State Medical Society, and reads as follows:

"At the meeting of the Board of Trustees on October 27, Mrs. A. Haines Lippincott appeared before the Board and asked the support of The Medical Society for the American Society for the Control of Cancer. The Trustees referred the matter to one of their members, Dr. Thomas B. Lee, of Camden, who is consultant to the Committee on Cancer Control, and requested me, as Chairman of the Welfare Committee, before November 28th to consider this matter."

It was brought to the attention of Dr. Lee from the report of the Cancer Control Committee of the New Jersey State Society adopted by the delegates and reported in the Journal of May, 1940, page 243, as follows:

"Our committee again recommends that the work of the Curie Institute and the American Society for the Control of Cancer be supported in their respective fields in such counties where these organizations have sought for and received approval of the local County Medical Societies."

The following motion was then made by the Cancer Committee of the State Society to Dr. Ewing and the *American Society for the Control of Cancer*.

"That of the first \$10,000.00 collected by the Women's Field Army, 30 per cent of the enlistment shall be refunded to the National Organization, and on the second \$10,000.00,

20 per cent shall be refunded to the National Organization, and on the third \$10,000.00 10 per cent shall be refunded to the National Organization, and five per cent thereafter."

It was then recommended and approved by the committee that Motion No. 1 adopted and passed by the committee at the meeting on October 25th, 1940, be referred to the Public Health Committee of the New Jersey State Medical Society as follows:

"That this committee go on record as favoring registration of all cancer cases possible, in the State of New Jersey, through hospital registration and individual doctor's registration. That this registration be in the form of a confidential report rather than a public report and that an envelope should be included with each report and be forwarded to a central agency."

All voted in favor and it was so ordered by the Chairman.

A meeting of the Cancer Control Committee was held on January 23, 1941. Seven members of the committee were present.

A motion was made and adopted that the State Board of Health hire a statistician on full time to register and follow up all cancer cases. Dr. Snegireff agreed to present this matter to the State Board of Health and to the Welfare Committee.

A motion was made and adopted by the committee to invite the representatives of the Curie Institute and the American Society for the Control of Cancer to a meeting with the Cancer Control Committee of The New Jersey State Medical Society.

The next meeting was held on April 11, 1941.

The annual report by the Chairman was acceptable to all members present and it was agreed that it be sent to the Executive Secretary of The New Jersey State Medical Society.

The question of registration and follow-up of all cancer cases in the State of New Jersey was widely discussed at all the meetings and adopted with enthusiasm by the entire committee. It is believed that this will eventually be of great value both as to finding out the best method of treatment, the most satisfactory method of treatment and results. Until the definite report of results of the treatment of cancer is widely discussed and realized by the medical profession no definite progress in the treatment of cancer can be carried out. Is surgery the best method, is x-ray the best method, is radium the best method of treatment, and which kind of cases and for what class of cases with the least amount of disturbance to the patient and the least method

of dissemination of the disease? That is the only way a definite determination can be made of the results of cancer treatment by the general medical profession and the future best method of the treatment of these patients.

There are many good clinics for the treatment of cancer established in New Jersey. They are manned by competent men especially equipped for the treatment of cancer. The Cancer Control Committee urges that more of these clinics be established and that a definite correlation and follow-up and statistical notation of the results of the work of these cancer clinics and hospitals be reported.

Unless there is some form of compulsory registration of all cancer cases, the results of the treatment of cancer will never be determined. It is true that some of the large national clinics have such a follow-up system and they can give definite figures of their results. We must know what the general profession has been doing to accomplish cancer cures.

The Cancer Control Committee definitely approves of such registration and this was reported to the Public Health Committee and the Welfare Committee at the meeting on February 9, 1941.

RESOLUTIONS

The four resolutions of the Cancer Control Committee were unanimously endorsed by the Public Health Committee and the Welfare Committee at that meeting.

The four resolutions were:

1. To make cancer a reportable disease in New Jersey.
2. To request the Department of Health to make provision for additional staff members professionally qualified to undertake epidemiological studies in the fields of cancer and other public health fields.
3. Approval of the Curie Institute and American Society for the Control of Cancer in their respective fields and in such counties where they have been approved by the County Medical Society.
4. A new basis for the distribution of funds collected locally to provide a larger percentage of return within the State.

Respectfully submitted,

EDGAR A. ILL, *Chairman*
OTTO R. HOLTZ, *Vice-Chairman*
WILLIAM G. HERRMAN
CHARLES B. WOODMAN
THOMAS J. SUMMEY
WILLIAM O. WUESTER
PHILIP AVERY
WILLIAM ANTROPOL
NICHOLAS M. ALTER
LEONID S. SNEGIREFF
WILLIAM SPICKERS
F. E. KEIR
THOMAS B. LEE, *Consultant*

REPORT OF THE ADVISORY COMMITTEE ON CHILD HEALTH

By CHESTER R. BROWN, M.D., Chairman, Arlington, N. J.

To the Sub-Committee on Public Health:

On July 12th, 1940, the Committee held a meeting at the Academy of Medicine, Newark, for the special purpose of getting an early start on the Premature Program, which had been approved by the House of Delegates at the meeting in June. It was directed that our Committee should present the program to the Presidents of the several County Medical Societies with the request that they present it to the County Child Health Committees for promotion. (See March, 1941, Journal, p. 137.)

The sixteen-point-premature program reached the County Presidents before they opened their meetings in the Fall.

In Essex County it was given to the County Child Health Committee, who adopted and passed it on to the Maternal and Hospital Committee. The program was adopted by that group and passed by the Council, who in turn presented it to the Society at a regular meeting, where it was passed. The County Society office then sent a copy to the chief of every hospital in the county which took maternity cases, with the request that they adopt these principles in the care of prematures.

All County Societies were requested to have a child health program at one of their meetings. As far as we know, this was only accomplished in Essex.

At this July meeting the Child Health Committee officially notified the State Medical Society that it would coöperate with any official agencies in the medical care of refugee and visiting children.

On November 20th Dr. L. Charles Rosen-

berg and your Chairman met with representatives of the Newark and State Boards of Health to discuss recommendations for establishing a state-wide standard of diphtheria immunization. We are still working on the problem.

Your Chairman attended the November and February meetings of the Welfare Committee.

By invitation, your Chairman attended a meeting in Newark on March 27th of the Conservation of Vision Committee for the discussion of more accurate reports on ophthalmia neonatorum. A committee of two was appointed by the Chairman, Dr. Elbert S. Sherman, to make a study of the condition and make a report at a later meeting.

Arrangements have been made for a Child Health Exhibit at the State Society Annual Meeting in May.

A Speakers' Bureau has been established to further child health post-graduate teaching, with special reference to premature care. These speakers will be furnished to the County Societies upon request.

Literature will be provided in reprint form after publication in The Journal, emphasizing the value of tuberculin testing, having in mind the education of parents as to this procedure.

Respectfully submitted,

CHESTER R. BROWN, *Chairman*
STANLEY NICHOLS, *Vice-Chairman*
WALTER B. STEWART
ARTHUR F. ACKERMAN
ERNEST G. HUMMEL
L. CHARLES ROSENBERG
FREDERIC J. LATHROP
IRVING OKIN
ARTHUR HEYMAN
J. PHILLIP STOUT
ALDRICH C. CROWE, *Consultant*

REPORT OF THE ADVISORY COMMITTEE ON CONSERVATION OF VISION

By ELBERT S. SHERMAN, M.D., Chairman, Newark, N. J.

To the Sub-Committee on Public Health:

There have been two meetings of the Committee—on October 24th and on March 27th.

APPROVED LIST

At the October meeting the names of twenty-four ophthalmologists were approved and recommended to the New Jersey Commission for

the Blind, for addition to the original list submitted by the Committee for examining applicants for blind relief. During the past year the examination forms approved by the Federal Social Security Board have been used, and a fee has been paid for each examination. Possibly these are reasons for the improvement that has been noted in the character of these reports.

OPHTHALMIA NEONATORUM

As requested by Chairman Nichols of the Public Health Committee at the February meeting, Mr. MacDonald of the Health Department and Dr. Chester Brown of the Child Health Committee met with our Committee at the recent meeting for the purpose of discussing the *unsatisfactory reporting* of cases of ophthalmia neonatorum.

The Committee recommends, for the purpose of public health administration, the term "conjunctivitis of the new-born" as a substitute for ophthalmia neonatorum, and suggests the following working definition:

"Any inflammatory redness or swelling of the eyes or eyelids of a child, occurring within three weeks after birth, and accompanied by any mucous or muco-purulent secretion in which any pathogenic micro-organism can be demonstrated."

REFERRALS

During the year our Committee has dealt with various matters referred to it by the Executive Officer of the Society and others, and has been in active coöperation with the New Jersey Commission for the Blind and the National Society for the Prevention of Blindness. The Federal Security Agency of the

Social Security Board has elaborated a plan for a statistical study of blindness among applicants for the aid to the blind in various States, and has asked New Jersey to coöperate. This necessitates, among other things, the selection of a State Supervising Ophthalmologist. Our Committee has endorsed the plan. The matter is now being considered by the Commission for the Blind, and will probably be approved and steps taken to put it in effect at an early date.

INVESTIGATION

The Committee was recently asked to investigate an organization called the American Eye-Sight Service, which advertises "complete glasses as low as \$3.75" and examinations by "noted Newark ophthalmologists" for one dollar. Information concerning this group may be had from our Committee.

Respectfully submitted,

ELBERT S. SHERMAN, *Chairman*
GEORGE J. HOLMES, *Vice-Chairman*
HALVOR L. HARLEY
WALLACE PYLE
ENOCH BLACKWELL
CHARLES H. SCHLICHTER
JAMES S. SHIPMAN
JOSEPH H. KLER
WILLIAM E. BOOZAN
DAVID C. BRAUN
ELIAS J. MARSH, *Consultant*

REPORT OF THE ADVISORY COMMITTEE ON CRIPPLED CHILDREN

By ELMER PETER WEIGEL, M.D., Chairman, Plainfield, N. J.

To the Sub-Committee on Public Health:

During the past year the activities of the Advisory Committee on Crippled Children have been very definitely associated with the activities of the Governor's Crippled Children's Commission. Dr. Frederick G. Dilger, for many years a member of our Committee, has recently been appointed a member of the Crippled Children's Commission, and Dr. Barclay Moffat, a former chairman of the Crippled Children's committee, has been appointed as Medical Director of the Crippled Children's Commission. In this capacity they have represented the interests of The Medical Society as a whole, and the orthopaedists individually, in all crippled children's activities in the State.

There have been frequent conferences of the Chairman of the Crippled Children's Com-

mittee and our representative on the Commission, and distinct progress has been made, both in the care of the crippled children throughout the State and in preparation for epidemics, which might develop at any time.

Also, the organization of the National Foundation for Infantile Paralysis has progressed considerably, and at the present time almost the whole State is represented by individual chapters which are organized to care for unfortunate victims of infantile paralysis, not only in children, but adults as well. This activity has been a distinct help to those of us interested in the crippled children, because it gives us some funds which may be made available for those individuals who have unfortunately outgrown the age limit.

There are many problems that remain unsolved, the outstanding one being the question

of compensation for the physician doing orthopaedic work for Federal and State charges. This matter has been discussed at many conferences between the Crippled Children's Committee and the representative of the Children's Bureau in the Department of Labor which controls all Federal Security funds.

While it is difficult at this time to predict what may come of these conferences, I feel

safe in saying considerable progress has been made in this difficult problem.

Respectfully submitted,

ELMER PETER WEIGEL, *Chairman*
TOUFFICK NICOLA, *Vice-Chairman*
FREDERICK G. DILGER
SETH B. SPRAGUE
OSWALD R. CARLANDER
JAMES P. PREGNALL
JOHN E. TOVE
WILLIAM F. COSTELLO, *Consultant*

REPORT OF THE ADVISORY COMMITTEE ON MATERNAL WELFARE

By ARTHUR W. BINGHAM, M.D., Chairman, East Orange, N. J.

To the Sub-Committee on Public Health:

The Committee on Maternal Welfare is completing ten years of service. For its origin see Transactions, House of Delegates, 1931, page 42, printed as a supplement to the Journal of August, 1931.

What the committee has accomplished is indicated by the progressive decrease in the maternal mortality rate. In 1931, when the work was started, the rate was 5.9 per 1,000 live births. The rate for 1940 was 2.9 per 1,000—more than cut in half. Figuring on the number of births each year, there are 904 mothers alive today who would have died had the rate remained the same as in 1931. In 1940 alone the number is 175.

The committee has adhered to the twelve-point program which was announced in the Journal of December, 1936, page 716.

1. THE COMMUNITY HOSPITAL

It is safe to state that every hospital in the State is now interested in maternal welfare. They have posted rules of procedure and rules for consultation in abnormal cases which are enforced in most instances; and they are trying to isolate their obstetrical departments.

2. OBSTETRICAL CONFERENCES

Regular obstetrical conferences are open to all physicians interested in obstetrics. This is one of the special features that are being stressed this year. A number of counties are holding these conferences regularly, and it is expected that others will soon organize them. Maternal deaths and difficult cases are dis-

cussed and there is no doubt of the educational value of these conferences. Some of the counties that have only a few deaths have joint conferences.

3. LECTURES

Lecture courses are given from time to time; and when there is no regular lecture course, each county devotes at least one meeting each year to the discussion of obstetrical subjects.

4. REFRESHER COURSES

Refresher Courses are given without charge to any physician in the State who wishes to spend from a few days to a few weeks at Margaret Hague Maternity Hospital in Jersey City. A letter of recommendation from the chairman of the Committee on Maternal Welfare is all that is necessary.

5. FIELD PHYSICIANS

Field Physicians have been of valuable assistance to the committee. Their duties are many, and have been stated several times in previous reports. We are grateful for their cooperation.

6. MATERNAL DEATHS

The study and classification of maternal deaths is an important part of the work, and leads to more accuracy in statistics. One result of this work is that more accurate statements are being made regarding causes of deaths, for this is necessary in order to correctly classify the deaths. All reports of deaths connected with pregnancy are now sent to the field phy-

sician for investigation; and are then sent to the chairman of this committee for classification, instead of being classified before the investigation, as was formerly done. By this procedure it is easier to determine whether it is really a maternal death or not.

The findings are then sent to the State Registrar for his information. This may lead to finding more maternal deaths which formerly were obscure; but our statistics will be as accurate as can be obtained anywhere.

7. OBSTETRICAL REPORTS OF HOSPITALS

One hundred annual obstetrical reports of hospitals are received. They are not simply filed away; but they are studied as to the number of deliveries, Cesarean sections, toxemias, hemorrhage, stillbirths, and deaths, etc.;—and the findings are tabulated. The maternal deaths reported are compared with the histories on hand, and frequently the two do not agree. This is often due to the death certificate being carelessly filled out by an intern who does not always give the true cause of death. After corresponding with one hospital a reply was received giving two different causes of death for each case:

- a. That given on the death certificate; and
- b. That on the obstetrical record.

Since it is important, for the correct classification of deaths, to have the right diagnosis, every attending physician should check the death certificate before it is mailed. This would save a great deal of correspondence.

When death occurs within three months of pregnancy, the pregnancy must be mentioned on the death certificate. Where there is a disease complicating pregnancy the date of onset of the disease should be stated on death certificates. The incidence of Cesareans, stillbirths, and neonatal deaths varies considerably in the different hospitals. Most of the hospitals are using the new *obstetrical record book* that was published in the Journal of June, 1940, page 325. On the whole, the hospital obstetrical records are becoming more accurate; and it is felt that an effort is being made to improve obstetrics all over the State.

8. NURSING DELIVERY SERVICE

The nursing delivery service is widely used. A physician having a home delivery in the low-wage group may call a graduate nurse, and she will be paid by the State Department of Health

through the Bureau of Maternal and Child Health.

The consultation service is frequently used. A physician needing consultation may call any competent physician, and the consultant will be paid in the same way. Except in an emergency, one of the listed consultants should be called. The field physician has the list.

9. SYSTEMS OF PRENATAL CARE

The importance of prenatal care is constantly stressed. Two systems are offered for the low-wage or indigent group of patients:

A. The maternity center system, in which there are prenatal centers and visiting nurses working together; and

B. The community system, in which the visiting nurses report cases to the field physician; and he assigns the patients to physicians in the neighborhood for prenatal care. Both systems are in use, but more should be organized.

10. MATERNAL DEATHS

A statistical study of maternal deaths is published each year (see August Journal) showing how the counties stand regarding their *total* maternal mortality rates, and also the mortality rates assigned to each of the five main causes of maternal deaths.

11. MATERNAL WELFARE ARTICLE

A maternal welfare article is published in the State Medical Journal each month, except the month when the program for the annual meeting is published, when there is not sufficient space. This has been carried on for over five years.

12. LESSON FROM A DEATH CERTIFICATE

A very brief paragraph entitled "A Lesson from a Death Certificate" is published eleven months of the year in the State Medical Journal. These brief resumes of cases have proved quite popular; and according to various reports they are read by physicians in other States, as well as by our own members. These lessons have been mimeographed, and are available for use in obstetrical conferences when desired.

The twelve-point program as carried out all over the State of New Jersey includes most of the features of maternal welfare. The chairman has visited many counties to explain some of its details. The work seems to progress

slowly, but it *progresses*, and the results are gratifying.

We greatly appreciate the fine coöperation of Dr. Wilkes, Dr. Scott, and Dr. Overton, and their associates in the executive offices; Dr. Levy of the Bureau of Maternal and Child Health; Mr. Walter R. Scott, State Registrar of the State Department of Health; Dr. Ellen C. Potter of the Department of Institutions and Agencies; the several county Maternal Welfare Committees; the hospitals; and maternity homes, as well as the social service agencies; the physicians; and the nurses,—all

of whom have helped to make this work a pleasant task.

Respectfully submitted,

ARTHUR W. BINGHAM, *Chairman*
J. CARLISLE BROWN, *Vice-Chairman*
SAMUEL A. COSGROVE
WALTER B. MOUNT
ROBERT A. MACKENZIE
J. HARRIS UNDERWOOD
HARRISON B. WILSON
MAYNARD G. BENSLEY
CARL H. ILL
JULIUS LEVY
HAMMELL P. SHIPPS
WILLIAM M. SULLIVAN, JR.
WILLIAM HEATLEY
GEORGE B. GERMAN
WILLIAM K. PUDNEY
THOMAS B. LEE, *Consultant*

REPORT OF THE ADVISORY COMMITTEE ON MENTAL HYGIENE

By JOSEPH E. RAYCROFT, M.D., Chairman, Princeton, N. J.

To the Sub-Committee on Public Health:

Continuing the work of last year, the Advisory Committee on Mental Hygiene reports that during the current year the proposed survey of psychiatric services has been carried out. Contacts with the larger hospitals have been made and data gathered. A suggestion has been made that a staff psychiatrist be made available to other hospital staff members and that advantage be taken of his special training and experience in dealing with nervous and emotional states, particularly when these conditions serve to confuse the clinical picture and to mask the real underlying cause of the symptoms about which the patient is most concerned.

The reception of this suggestion, and the co-operation manifested by hospital staffs and Trustees, has been most encouraging and has resulted in some additional provisions for psychiatric services.

Two dramatic presentations of common emotional problems by a cast composed of trained and experienced staff members of the Marlboro State Hospital were arranged and one has already been given in Monmouth County. This form of teaching is proving to be not only instructive but stimulating enough to enlist and maintain the interest of general practitioners who quickly recognize the types presented in these sketches as replicas of similar patients in their practice. These patients have caused doctors much worry and anxiety, and the doctors have many times wished themselves more adequately prepared to be of service in these cases. The Committee hopes it will be possible to arrange to present these

sketches in each county upon request of and under the auspices of the County Medical Society.

The Journal has been and will continue to be used as a medium to call to the attention of our members such helpful suggestions and references in the literature as more intensive study by the Committee members brings to their attention. It is planned to encourage the hospital libraries to add to their available reference collections books and articles recommended by our Committee. In the Journal our members will also find periodic reports on the meetings, activities and discussions of this Committee.

The Committee plans to participate actively in the development and promotion of other mental hygiene programs which seem sound, and to help in keeping a balance in this field where unsound programs and procedure could do much harm.

In this connection the attention of the Committee has been called to a growing tendency on the part of those engaged in work with children and adolescents to fail to distinguish between the scope and function of the medically trained psychiatrist and those of the non-medical psychologist in providing service for clinical cases complicated with nervous or emotional maladjustment. This situation should be frankly recognized, and arrangements made for conferences by representatives of the groups concerned to the end that the distinction noted should be clarified and formulated for the guidance of those concerned.

A sub-committee was appointed to discuss

with Mr. Wann of the Teacher's Association Mental Hygiene Committee the aims, organization and scope of this Committee, the purpose being coördination of aims and activities of all such mental hygiene efforts in New Jersey.

The Agricultural Extension Division Director of Rutgers University sought the coöperation of the Committee on Mental Hygiene in a program of radio broadcasts which she was arranging. The Committee, however, felt that inadequate time was available to make participation at this time in such a program advisable, and for this and other reasons, active participation this year was not recommended to the Medical Society.

One of the greatest obstacles to the identification of emotional and neurological factors lies in the misleading record of case histories due to the omission or denial of information because of the supposed social stigma which the public still attaches to the presence or

report of mental disease or disfunction in any member of a family group. Every physician should assist in the dispelling of this unfair stigma. He can in this way render a real service to such families.

The mental hygiene aspects of perivascular disease will be discussed by one of our Committee members in our Annual Meeting symposium.

The Advisory Committee on Mental Hygiene has held four meetings up to April 1st, 1941.

Respectfully submitted,

JOSEPH E. RAYCROFT, *Chairman*
JOHANNES F. PESSEL, *Vice-Chairman*
CLARENCE M. TRIPPE
HENRY A. DAVIDSON
WILLIAM M. DOODY
ARTHUR C. ZUCK
J. BERKELEY GORDON
ELIC A. DENBO
JULIUS LEVY
CARL H. ILL
KARL ROTHSCHILD
AMBROSE DOWD, *Technical Adviser*
GEORGE STEVENSON, *Technical Adviser*

REPORT OF THE ADVISORY COMMITTEE ON PNEUMONIA CONTROL

By THOMAS M. KAIN, M.D., Chairman, Camden, N. J.

To the Sub-Committee on Public Health:

The Advisory Committee on Pneumonia Control has held no meetings during this year and therefore has no activities to record for the current year.

Respectfully submitted,

THOMAS M. KAIN, *Chairman*
FRED VOSBURGH
CHARLES F. RATHGEBER
CLAUDIO E. MCNENNEY
LEONARD M. BERMAN
FRANK J. ALTSCHUL
SAMUEL ALEXANDER, *Consultant*

REPORT OF THE ADVISORY COMMITTEE ON TRAFFIC ACCIDENTS

By MILLARD F. SEWALL, M.D., Chairman, Bridgeton, N. J.

To the Sub-Committee on Public Health:

At a conference early in the year with the State Highway Commissioner, Hon. Arthur W. Magee, the hope was expressed that the Traffic Accidents Committee of the State Medical Society might be able to collect for him some statistics on which to base new regulations in issuing licenses to those suffering from pathological conditions which might make them liable to accidents in operating an automobile on the public highway.

The lack of such statistics and the difficulty in collecting them was apparent. The whole-hearted coöperation of the State Medical Society was requested.

It was at first thought that a State-wide survey of all pathological cases might be made

through contact with the individual physicians. This, however, did not have the approval of the Welfare Committee as a state-wide proposition. The suggestion was then made that one county might be studied for a statistical estimate on which to base the percentage of cases coming under this classification to show the necessity of inaugurating new laws to regulate the granting of license.

This has been done in Cumberland County and from this summary it would appear that slightly less than two per cent would be affected.

This Committee has already advised the examination of applicants for license at age 65, again at 70, again at 75 and yearly thereafter.

Regulations requiring physicians to report to

the Commissioner of Motor Vehicles all cardiac, kidney, diabetic, mental or other pathological conditions, including vision, which in their judgment required a special examination before license is issued, would be necessary.

Because of the professional and possible legal difficulty in securing the above data through the Medical Society, we recommend that The Commissioner of Motor Vehicles incorporate questions on the application blanks to give him the desired information.

It does not seem quite logical to leave any stone unturned to eliminate accidents by neg-

lecting a thorough periodical examination of these drivers.

We are all well aware that the routine inspection of automobiles, as practiced at present, is an excellent precaution. Why neglect equally important precautions in the drivers?

Respectfully submitted,

M. F. SEWALL, *Chairman*
CHRISTIAN P. SEGARD, *Vice-Chairman*
THOMAS S. P. FITCH
PHILIP W. BAKER
CLARENCE P. LUMMIS
LEROY W. BLACK
WILLIAM CALLERY
J. HOWARD HORNBERGER, *Consultant*
ARNOLD VEY, *Technical Adviser*

REPORT OF THE ADVISORY COMMITTEE ON TUBERCULOSIS

By ABRAHAM E. JAFFIN, M.D., Chairman, Jersey City, N. J.

To the Sub-Committee on Public Health:

While the past year has been one of fewer meetings than usual, the Tuberculosis Advisory Committee has had to concentrate rather intensively on a few major activities, as follows:

1. CASE-FINDING REPORT

This dealt with an elaboration of a discussion of the various tuberculin-tests, x-ray procedures, and other data connected with tuberculosis surveys, with particular reference to high schools and colleges. It was presented as a report which was based on questions submitted by the New Jersey Tuberculosis League to the Chairman at the Spring Conference of the League at Princeton in May, 1940. The Committee devoted several meetings to a careful consideration of the many technicalities involved. Finally, after several months, the report was adopted with such modifications as to make it more generally useful throughout the State. It was finally approved on September 11, 1940, and published in the January, 1941, issue of the Journal of the State Medical Society. Because of the many requests for copies, the State Tuberculosis League ordered 5,000 reprints which are being distributed to school officials, tuberculosis leagues, physicians, and others interested in tuberculosis surveys.

It is also gratifying to note that requests came from points as far West as Minnesota, and that the National Tuberculosis Association has just requested 100 reprints. The Committee believes that this report represents a concise summary of the best opinions on the subject to date and should serve as a reliable guide to those who are interested in the subject.

2. TUBERCULOSIS CASE-FINDING IN MEN INDUCTED INTO THE ARMY

Early last October your Committee urged that the State Medical Society, through the Committee on Medical Preparedness, make arrangements for a chest x-ray of every man prior to his actual induction into the army, while still a civilian. The reasons for this action were clearly stated in resolutions which were adopted by the Public Health Committee. Shortly thereafter, October 24th, word was received from the Surgeon of the Second Corps Area that the Army would welcome this effort until it could set up its own equipment and personnel to carry out this necessary part of the induction examination.

At a conference held on October 24th, the Chairman of the Tuberculosis Advisory Committee and Dr. Norman M. Scott, Secretary of the Committee on Medical Preparedness, entered into an arrangement with the Surgeon of the Second Corps Area to provide an x-ray of every selectee at his induction station, and to have the report ready before he was through with the other examinations of the day.

On November 3rd, a joint meeting of the Medical Preparedness Committee and the Advisory Committee on Tuberculosis was held at the Executive Offices. Ways and means were provided for necessary x-ray services at the four induction stations (Newark, Trenton, Somerville, and Camden).

With the aid of Drs. Collier, English, Morrow, Runnells, and your Chairman, x-ray service was provided at these four stations. Drs. Collier, Morrow and Runnells served as internists on the induction boards, assigned to

interpret the films. In January, the Camden and Somerville Stations were merged with Trenton and Newark, respectively.

The total number of draftees x-rayed from November 25th to March 14th at these stations was 14,552. In this number, 98 cases of tuberculosis were discovered, making an incidence of 0.67 per cent, or almost seven cases per 1,000 men. An additional 364 men of the New Jersey National Guard Troops (colored) were also x-rayed, revealing six more cases of tuberculosis.

It was the privilege of your chairman to make a complete report to date of the work of the Committee and the Committee on Medical Preparedness in the form of a paper on *Tuberculosis Among Draftees*, which was read at a joint meeting of the Sanatorium Conference of Metropolitan New York, and the New York Tuberculosis and Health Association last March. The contrast of modern methods of case-finding in group surveys as compared with the problem that faced us in 1917 was discussed, and the great ultimate economy of the present method was emphasized.

3. SCHOOL SURVEYS

The Committee feels deeply the irreparable and untimely loss of Dr. Allen G. Ireland whose death last October 24th was deeply mourned. His interest and coöperation in the work of this Committee could not have been greater, and was always welcomed by all of its members. Fortunately his place has been well filled by Miss Lula P. Dilworth, who has already demonstrated a sincere interest in effectively administering the new laws to eliminate tuberculosis from our schools. Our progress in New Jersey as pioneers in this effort is being watched with interest by other States, and frequently referred to at tuberculosis meetings.

4. POST-GRADUATE COURSES IN TUBERCULOSIS

It affords me great pleasure to be able to report that two courses have been arranged for this Spring; one in Newark, and the other in Hudson County. It is unfortunate that these happen to run concurrently. Nevertheless, they offer a liberal opportunity to the physicians throughout the State to acquaint themselves with the latest information on the various subjects to be discussed. Dr. LeRoy A. Wilkes and Dr. Stuart Z. Hawkes have been very

helpful in arranging the Hudson County course.

5. CASE-FINDING IN THE APPARENTLY WELL

The value of a chest x-ray in the apparently well as the easiest and best method of finding unknown cases of tuberculosis has been definitely established (Edwards, Prest, Myers, et al.). The fact that most of the cases found are in the minimal stages, and promptly curable, makes this method all the more desirable and valuable. A large percentage of the cases thus found will naturally seek the advice of their private physicians. It is to be hoped that these findings will not be minimized because of the lack of clinical signs or symptoms, but will be given due consideration. There is need for a better understanding of this problem by the medical profession. Objections based on erroneous economic ideas are retarding a most productive means of case-finding, that would be to the mutual advantage of the public and profession.

The 1941 slogan—*A good x-ray is your Doctor's best aid in discovering early tuberculosis*—confirms the above conclusions and deserves the united support of the entire medical profession.

In closing, I wish again to express my appreciation for the interest and coöperation of all the members of the Committee. We are particularly indebted to Drs. Collier, English, Morrow and Runnells, who are still serving at the induction stations, and who at the beginning assumed the heavy burden of organization at considerable personal sacrifice. The success of the x-ray project at the induction stations has been due to the effective coöperation of these members of the Committee with Dr. Norman M. Scott, Secretary of the Medical Preparedness Committee. His knowledge of military routine, and very sincere interest, saved us a good deal of time and many difficulties in the early preparation and organization.

Respectfully submitted

ABRAHAM E. JAFFIN, *Chairman*
JOSEPH R. MORROW, *Vice-Chairman*
JOHN E. RUNNELLS
HAROLD S. HATCH
SAMUEL B. ENGLISH
CLYDE M. FISH
LEO B. DRAKE
THOMAS H. MCGLADE
NORMAN W. BURRITT
J. EARLE STUART
MARTIN H. COLLIER
GEORGE J. YOUNG, *Consultant*
HENRY H. KESSLER, *Technical Adviser*

REPORT OF THE ADVISORY COMMITTEE ON VENEREAL DISEASE CONTROL

By C. BYRON BLAISDELL, M.D., Chairman, Long Branch, N. J.

To the Sub-Committee on Public Health:

The work of this Committee has proceeded during the year consistently with the program advocated last year. The activities had to do with:

1. CLINIC EXTENSION

In 1939 there were thirty-six clinics operating in New Jersey which increased to eighty in 1940 and which have now risen to eighty-nine. In 1940 176 doctors were employed in these clinics. This number has risen to 191 in 1941. Of these, 101 received remuneration last year in contrast with 86 this year. For their services doctors were paid \$31,000 last year and have received \$32,000 this year.

2. FREE DISTRIBUTION OF DRUGS

The State Department of Venereal Disease Control has continued to provide drugs necessary for the adequate care of all venereal disease patients. An additional drug, sulfathiazole, has been added this year for the treatment of gonorrhea. Whereas at the beginning of the current venereal disease campaign in 1936 only \$6,000 per year was spent, this amount is now \$40,000.

3. APPOINTMENTS OF DOCTORS FOR CLINICS

The County Medical Societies have continued to supply names of doctors applying and approved for new clinic positions. This Committee wishes to emphasize the importance of supplying two or more physicians' names for any position available so that the State Department of Health and local health boards may have a choice of physician. As the spread of Regional Health Commissions continues and local funds play a larger part in supporting the work against the genito-infectious diseases, there will unquestionably be more interest in the selection of the physicians. In our opinion, the Medical Society should continue to influence that choice to the end that the best quality of medical service be maintained.

4. CASE REPORTING

The profession is urged to take seriously its responsibility for reporting all cases of genito-

infectious diseases. Dr. Kessel of our Committee has been deeply interested in this phase of the work and writes as follows:

"The need for reporting all cases of syphilis and gonorrhea is more necessary than ever. Without such information the effectiveness of the present-day therapy and the adequacy of clinic facilities cannot be estimated. The prevalence of venereal disease as shown by case reporting is also taken into account when Federal funds are allocated to each State. Thus more complete reporting of cases of syphilis and gonorrhea will be of help to the State Department in securing these funds."

We need hardly point out our greater responsibility in this time of troop concentration and defense worker concentration.

5. COUNTY VENEREAL DISEASE COMMITTEES

This Committee feels that the County Venereal Disease Committees are and should be composed of the men best informed on the incidence and treatment of the disease involved. In appointing these committees, it would be well for the County Society Presidents to bear in mind two important considerations:

a. That the members appointed be capable in their specialty, as well as to be able to get along with the workers in other agencies interested in venereal disease control.

b. That they seek to preserve for the private practitioner the treatment of all cases which should come to his office either at full or part-pay rates.

6. EDUCATION

During the past year 251 members of our Society attended courses given under the auspices of the State Department of Venereal Disease Control. These courses consisted of twelve two-hour sessions and the attendance reported was for nine of the twelve sessions. New courses will be held this April and probably again this Fall. Members who are interested in filling clinic positions should avail themselves of this opportunity to have their knowledge of venereal disease control brought up to date. Following is a summary of the spread of information to the public and those interested in this public health problem.

	No. of Lectures	No. Persons Attending	No. Movies Shown	No. Persons Attending	No. Folders, Leaflets, Pamphlets, Booklets, Posters
1936-37	365	43,433			61,615
1937-38	423	45,500			134,527
1938-39	320	44,951	79	3,862	123,776
1939-40	266	39,464	98	11,153	48,000
*1940-41 (% of 1 yr.) . .	94	33,444	107	20,894	251,526

* Up to March 25, 1941

This does not take into consideration the many radio talks given throughout the year. Special mention might be made of the course given to public health nurses on the subject of "Public Health Control of Venereal Disease" run as an extension course of Rutgers University.

Finally, a new form of sticker campaign will be conducted, and samples of these stickers will be available for members of the Society very shortly.

NEW PROJECTS

The first and newest enterprise in the venereal disease field has been connected with defense works and the mobilization of troops. Wassermann testing of inductees has revealed already approximately 1000 draftees found to be infected, many of whom will become local problems for treatment. Both private physicians and clinics must be ready to absorb this new load and give thorough treatment. Under Dr. Bergsma's able direction follow-ups on all cases are planned.

Coöperative studies of the conditions surrounding army centers such as Forts Dix, Monmouth and Hancock, and some defense factory areas have been made by members of our Committee, members of the State Department of Venereal Disease Control and army medical officers. Local health authorities, state, county and local police and the commissioners in charge of public safety are coöperating

splendidly in fighting the spread of venereal disease and checking the conditions leading to it. To date, the figures have been very encouraging and show that young men in uniform and the young civilian population of the State are better informed and better protected than probably at any previous time.

A proposal of the State Department of Venereal Disease Control to do group blood-testing in defense industries was referred back to the Public Health Committee for reconsideration following an objection pointed out by one of the county societies that such group-testing might infringe on the rights of private practitioners. It was felt that further efforts should be made by the State Department of Venereal Disease Control to educate the workers so that they would voluntarily seek blood tests in the offices of private doctors. Replying to this suggestion the State Department is willing to coöperate with our Society to the utmost and continue its work of the past four years. This Committee urges that all physicians push this educational idea with all the pamphlets and stickers they can get hold of so that it will be given a good impetus.

Respectfully submitted,

C. BYRON BLAISDELL, *Chairman*
JOSEPH E. HIGI, *Vice-Chairman*
JOHN S. KESSEL
BAXTER A. LIVENGOD
IRVING LERMAN
ARTHUR J. CASSELMAN
DAVID W. GREEN, *Consultant*
DANIEL BERGSMAN, *Technical Adviser*

REPORT OF THE SPECIAL COMMITTEE ON MEDICAL PREPAREDNESS

By CHARLES M. SCHLICHTER, M.D., Chairman, Elizabeth, N. J.

To the House of Delegates:

The Medical Preparedness Committee, appointed by the President of The Medical Society of New Jersey in June, 1940, reported to the House of Delegates at its special meeting held at the Academy of Medicine, Newark, N. J., on November 28, 1940.

At that special session in November, the functions of the committee were explained in detail. The functions, in brief, are:

1. Organization of the medical profession in New Jersey for medico-military preparedness according to a plan submitted by the Surgeon-General of the U. S. Army to the House of Delegates of the American Medical Association on June 1, 1940, and adopted by that body.

2. Cooperation with the New Jersey State Defense Council.

The second objective is being accomplished through representation of this committee on the Sub-Committee of Health, Recreation and Welfare of the New Jersey Defense Council.

I. COUNTY COMMITTEES

County representation is accomplished through twenty-one paralleling county committees, appointed by the President of each respective County Medical Society. These county committees have functions which, in general, parallel the functions of this committee. They approve or disapprove of all physicians selected for appointment as examining physicians in their respective counties. They have made a definite contribution to the New Jersey Defense Council in the formulation of specific medical plans covering the care of the civilian population of their communities, applicable during a military or civilian emergency. Further development and coordination of these plans will proceed as requested by the New Jersey Defense Council.

II. COÖPERATING AGENCIES

Agencies with which this committee is co-operating are:

- A. The National Committee on Medical Preparedness of the American Medical Association.

- B. Office of the Surgeon-General of the U. S. Army.

- C. Office of the Surgeon, Second Corps Area.

- D. Office of the Adjutant-General of New Jersey.

- E. Offices of the Military Districts of New Jersey.

- F. Office of the Selective Service Plan of New Jersey.

- G. New Jersey Defense Council.

- H. Commanding Officers of the Induction Boards of New Jersey.

- I. New Jersey Tuberculosis League.

- J. American Red Cross.

The committee has held frequent meetings with cooperating agencies, and has consulted them at very frequent intervals. The progress of the committee as outlined at committee meetings has been reported in the recent issues of the Journal of The Medical Society of New Jersey.

III. MEDICO-MILITARY FACILITIES

As a basis for future procedures, the committee made quite an extensive study of medico-military personnel, organization and facilities in New Jersey. The results of this study were distributed in the form of four "Resumes", copies of which are on file in the Executive Offices of The Medical Society of New Jersey.

IV. MEDICO-MILITARY ACTIVITIES OF THE COMMITTEE

A. *Personnel Problems of Medical Examining Boards*

All physicians appointed as medical examiners are appointed upon recommendation of this committee from names suggested and approved by county committees. These names are submitted to the office of the Governor of New Jersey through the office of the Adjutant-General. Governor Edison requires a letter bearing the original signature of the Chairman or Secretary for each recommended appointment.

B. *Selective Service Boards*

Appointments to local Selective Service Boards were made in September, 1940, in accordance with instructions received from the National Committee of the American Medical Association, dated September 9, 1940. These lists were submitted to the office of the Adjutant-General of New Jersey and the Governor's office, and each name was registered with the American Medical Association as a medical examiner.

During our organization stage, there was some confusion in our relations with the office of the Adjutant-General of New Jersey. These difficulties have now been corrected, and there is now perfect understanding and coöperation between this committee and the above offices.

There are 202 local Selective Service Examining Boards. There were 606 initial appointments as medical examiners to these boards. The present medical personnel of these boards totals 936 physicians, each one appointed through the committee and recorded in our files and the files of the American Medical Association.

There are twelve Medical Advisory Boards with a total personnel, at present, of 151 physicians, all appointed through this committee.

There are eleven Appeal Boards, each containing one physician.

The physicians on all Selective Service Boards serve without pay. The contribution of their time, knowledge and experience is a manifestation of the best traditions of the medical profession. The true value of their services in protecting the efficiency and health of the armed forces, the health of the individual, and in determining the physical defects affecting the health of the general civilian population is beyond computation.

As the work of the Medical Examining Boards progresses, there is marked improvement in their results. This improvement is due to a fuller understanding of the Selective Service regulations and is manifested by the decrease in rejections by the Induction Boards. In the early stages of the work, rejections by Induction Boards were approximately 25 per cent. This has been reduced to the present figure of about 10 per cent.

C. *Induction Boards.*

In November, four Induction Boards were placed in operation. These Boards were located at Camden, Somerville, Newark and Trenton. The medical personnel of these Boards was carefully selected and was limited to men qualified in the various specialties. In January, the Boards in Camden and Somerville were closed and the entire work of the State was concentrated in Trenton and Newark. This called for no increase in the medical personnel of the two remaining Boards. In addition to the examination of the men of New Jersey, these two Boards have since carried on the physical examination of the men referred from the State of Delaware.

The medical work has run smoothly, with the examination load being cared for promptly each day, to the satisfaction of all concerned; and giving rise to commendatory reports by

the Army inspectors of the Second Corps Area. The work of these two Boards will continue until a permanent Induction Board is established at Fort Dix.

V. *INCIDENCE OF PULMONARY TUBERCULOSIS*

At the request of the Surgeon-General, U. S. Army, this committee, with the coöperation of the Committee on Tuberculosis of this Society, arranged for a chest x-ray, interpretation of the findings of each x-ray, and the recording of such findings on the examination form of each man examined by Induction Boards on the day of examination, at a cost of 75 cents per man examined. This work has been made possible because of the wholehearted coöperation of the Committee on Tuberculosis of this Society.

Portable equipment, as developed by Dr. Morrow of the Tuberculosis Committee, has been used in the Somerville, Camden and Trenton Induction Stations. The Powers X-Ray Corp. has done the technical work at the Newark Station, and deals directly with the Surgeon, Second Corps Area, rather than with this committee, insofar as payment of costs is concerned.

The committee wishes to extend its sincere thanks to the Committee on Tuberculosis for making this accomplishment possible. We are also appreciative of the coöperation given by the General Electric X-Ray Corp. through its local representative, Mr. Frank J. Mullowney.

In addition to the x-ray work done for the Induction Boards, this committee arranged for chest x-rays of each member of the 2nd Battalion, 372nd Infantry (colored), New Jersey National Guard. The committee assumed responsibility for the payment of costs of these examinations, there being, at that time, no authority for payment from Federal or State funds. The Adjutant-General of New Jersey, General Higgins, has since informed the committee that he is now able to assume responsibility for the payment of these costs.

VI. *MEDICAL PREPAREDNESS QUESTIONNAIRES*

Copies of the Medical Preparedness Questionnaire formulated by the Medical Preparedness Committee of the American Medical Association have been thoroughly distributed among the physicians of New Jersey on several occasions. These questionnaires contain basic data necessary for the proper distribution of physicians among the civilian population during an emergency and for the purpose of assigning men for duty in the military service during time of war. Proper coöperation of the profession in filling out and returning their

personal copies of this questionnaire is essential to any plan of medical preparedness adopted in this country.

Following the initial distribution by the American Medical Association, this committee distributed copies to each physician delinquent in the return of the personal questionnaire. The problem has recently been referred to the respective county committees, with the request that they make personal contact with the remaining delinquent physicians. Since December the list of delinquents has been reduced from 1970 to about 1050 physicians. Returns are now coming in as a result of the efforts made by the County Medical Preparedness Committees. The remaining delinquents are, for the most part, not members of The Medical Society of New Jersey. Some are not in active practice, and the remaining few are women physicians married to laymen. It will require personal contact in many instances to secure a return from these physicians.

VII. NEW JERSEY DEFENSE COUNCIL

The Chairman and Secretary of this Committee are members of the Committee on Health, Recreation and Welfare of the New Jersey Defense Council. In this capacity, they act in liaison between the Council, this Committee and The Medical Society of New Jersey. This Committee has been assigned the following functions by the Committee of the Defense Council:

A. To assist in formulating a medical plan as part of the Municipal Defense Plan of the New Jersey Defense Council. These plans are adaptable to the needs of each of our municipalities, and detailed plans are being worked out by the County Committees on Medical Preparedness in conjunction with the Mayors' Committees of the municipalities. There are, at present, 125 local defense committees concerned in the formulation of these plans. By orders of the Governor, these plans are being coordinated by the Superintendent of the New Jersey State Police. Involved in the plan, in addition to the physicians of each community, are the fire departments, police departments, transportation committees, public service and economic committees. Detailed medical plans, in most instances, must await further activity on the part of other cooperating committees.

B. To assist in formulating plans involving the transportation, medical care and distribution of civilians from New York City and Northern New Jersey to the rural areas of New Jersey. Medical aspects of this plan must await further detailed plans by other cooperating agencies and committees. The details of

the medical plan will depend on the decisions made by these other committees as regards routes of transportation and distribution of civilians within the rural areas.

C. Study of physical defects among rejected and deferred selectees. This involves monthly study of all medical examination reports with classification of diseases and physical defects under a recognized nomenclature of diseases. Such reports are submitted to the Committee on Health, Welfare and Recreation each month.

VIII. PHYSICAL REQUIREMENTS

It is difficult for many persons to understand why the physical requirements for inductees are of such high standards. It is necessary to have men as nearly physically, mentally and morally perfect as possible, because these men inducted during the first year will be the nucleus of a greater army if war should be declared. It is these men who will form cadres for future units, and who will act as instructors, non-commissioned officers and officers in the new Army.

Men with physical defects do not make good officers. The most frequent defects and the defects causing most controversy are dental defects. Young men with poor teeth are unsightly, subject to jests by their comrades, and represent, in general, a class of men who have practiced poor personal hygiene, have low personal morale and pride, and are not, in general, the type to make the best soldier or good officer. A similar remark applies to men with other defects which do not necessarily interfere with their activity in civilian life. Deferral of these men does not mean that they will not eventually be needed in the Army or that they will not make good soldiers in actual warfare under proper direction.

Careful selection assures low morbidity rates, higher military efficiency and less medical care, thus decreasing the Army demand for medical men now in civilian practice.

The third objective of this careful physical examination is the protection of the Federal pension rolls. It will help in protecting the next generation from the cost of supporting defective men who have had a short period of military service.

IX. PHYSICAL FITNESS OF SELECTIVE AGE GROUP

A study of our statistics relative to the physical condition of this age group might indicate that the general physical condition is far below what we might expect in this country. A more careful study will show that many of these defects are hereditary, that many are due to

careless personal hygiene, neglect and indifference. It indicates that many of the defects are minor in nature, and do not interfere with civilian life. Many of the defects, such as teeth and defective vision, will require large amounts of money to be corrected, which, as an investment, is probably not justified by the benefits which would accrue to the individuals. If these causes of rejection are disregarded, it becomes quite evident that the general physical condition of this age group is well within the expected limitations.

It must be remembered, also, that the screening process and the details of each examination have been much more carefully carried out than in previous periods of mobilization.

X. RESPONSIBILITY OF THE PROFESSION

A detailed study impresses one with the magnitude of the problem assumed by the medical profession. In accepting the plan submitted by the Surgeon-General of the Army, we have assumed responsibility for the physical fitness of all men inducted into the service. We have assumed responsibility for furnishing properly qualified physicians to care for the personnel of the Army, and we have assumed responsibility for the maintenance of the proper distribution of physicians among the civilian population. Thus the medical profession has been granted the opportunity, and assumed the responsibility of coöperating with the Federal Government in medico-military affairs during times of emergency.

XI. FUTURE PROBLEMS

Future problems of this Committee involve a continuance of its present activities. Its most pressing, immediate problem is to provide ways and means by which physicians of New Jersey may be supplied as medical officers of the Army to care for Army personnel.

The Committee, at its late meetings, has considered possible plans for furnishing this professional personnel. To date, no definite plan is ready for presentation.

The Committee is watching and studying the medical implications of the National Defense Plan, as that Plan may affect the distribution of medical care, and is ready at all times to coöperate with any other agency involved in controlling, or advising on proper distribution of medical care as altered by the National Defense Plan.

This Committee, and the profession in general, is involved in the National and State Defense Plans as follows:

1. *Selection and Mobilization of Physicians.*

This is being carried out by the A. M. A. with the State and County Societies' coöperation.

2. *Medical Examination of Selectees and Inductees.*

The Committee will continue this program in New Jersey in coöperation with Second Corps Area and the Selective Service Plan of New Jersey.

3. *Medical Care of Army Personnel.*

The Committee will coöperate in the selection of physicians for active duty at the approximate rate of $7\frac{1}{2}$ physicians per thousand members of the military establishment, including men of professional attainment to serve in the General Army Hospitals.

4. *Public Health in Areas of Mobilization.*

Public health control is not a direct function of this Committee, but the profession in general is involved through the efforts of the State Board of Health.

5. *Adjusting the Supply of Professional Personnel and Hospital Facilities.*

Another survey has been started which will determine the men eligible for active duty, those who will remain at home, the facilities offered by each hospital and the skeletal staff necessary to operate each hospital.

6. *A Rehabilitation Program for Selectees and Inductees Rejected Because of Physical Defects or Disease.*

Assistance in determining the necessity of and the promulgation of such a plan will be carried out by this Committee in collaboration with other agencies which may be involved.

7. *Nutrition.*

The nutrition of the general population, and particularly of those within the draft age, is a definite part of the National Defense Program. This Committee may, in the future, be called upon to coöperate.

8. *Industrial Hygiene in Defense Industries.*

This problem was presented to this Committee very recently, and steps are being taken to promote an industrial hygiene program in coöperation with the Industrial Health and Hygiene Committee of the State Society.

9. *Medical Care for Defense Workers in Industry.*

This is one of the problems of the future. The Committee is aware of its responsibilities regarding such a program, and through other committees and agencies of the Society will coöperate in the formulation of any proposed program.

10. *Program of Care of NYA Enrollees.*

This is a part of the National Defense Program which is, at present, being operated in all states as a physical examination program. The Committee stands ready to coöperate in this phase of the National Defense Program when called upon.

The Committee has received letters of com-

mendation and appreciation from Col. Charles Walson, Surgeon, Second Corps Area; William A. Higgins, Adjutant General of New Jersey; Hon. William J. Ellis, Chairman of the Committee on Health and Welfare of the New Jersey Defense Council; Dr. J. Lynn Mahafey, Commissioner of Health of New Jersey; and Audley F. H. Stephan, Chairman of the New Jersey Defense Council.

It is requested that the House of Delegates, by formal resolution, extend its thanks to the gentlemen named above for this evidence of their appreciation of our efforts.

XII. LIST OF EXHIBITS

There is attached to this report a summary and analysis of the work done by the Induction Boards of New Jersey up to and including March 31, 1941.

Respectfully submitted,

CHARLES M. SCHLICHTER, *Chairman*
DAVID B. ALLMAN
HAROLD D. CORBUSIER
WELLS P. EAGLETON
ALBERT O. HULETT
DAVID A. KRAKER
THOMAS K. LEWIS
ANDREW F. MCBRIDE
NORMAN M. SCOTT, *Secretary*

REJECTIONS BY INDUCTION BOARDS

November 25, 1941, to March 31, 1941

I. SUMMARY

	Mar. '41	Totals Nov. 25, '40- Mar. 31, '41
Selectees Examined	5,079	17,182
Rejected, Medical	652	2,187
Rejected, Non-medical	39	124
Total Rejections	691	2,311
Total Inductions	4,428	14,908*

* The error of three (3) reported last month still remains.

II. PERCENTAGE OF REJECTION

	Mar. '41	Totals Nov. 25, '40- Mar. 31, '41
Medical	10.9 %	12.7 %
Non-medical	0.77 %	0.7 %
Total	11.67 %	13.4 %

III. MEDICAL CAUSES FOR REJECTION

	Mar. '41	Totals Nov. 25, '40- Mar. 31, '41
Teeth		
Abscess, Alveolar		1
Abscess, Apical		1
Deficient Number	65	426
Dental Caries	19	25
Lymphadenitis, cervical, dental caries	1	1
Mal-occlusion	30	68
Pyorrhea Alveolaris	2	16
Tumor, left mandible	1	1
Vincent's Angina	1	1
Total	119	540
Eyes		
Blepharitis		2
Cataract		1
Cataract, traumatic	1	1
Conjunctivitis, acute	1	1
Conjunctivitis, chronic		1
Corneal Opacities		1
Dacrocystitis, chronic		1
Defective vision	17	227
Diplopia	2	3
Keratitis		1
Nystagmus		2
Ophthalmoplegia	1	1
Optic Neuritis	1	1
Strabismus	1	2
Total	24	245

	Mar. '41	Totals Nov. 25, '40- Mar. 31, '41
Nose, Throat and Ears		
Abscess, peri-tonsillar	1	1
Cleft Palate		1
Deafness, cause not stated	1	6
Disease, internal ear, undiagnosed	1	1
Diphtheria		1
Fistula—maxillary sinus		1
Hare Lip	1	1
Hay Fever	1	3
Hypertrophied Turbinate		2
Impacted Cerumen, bilateral ..	1	2
Laryngeal Paralysis		1
Mastoiditis, type not stated		1
Mastoidotomy, post-operative ..		1
Nasal Polypi		5
Nasal Septum, deviation	3	46
Nasal Septum, perforation	1	1
Otitis Externa	1	3
Oto-Sclerosis	1	1
Otitis Media, acute and chronic	18	86
Paralysis, auditory nerve		1
Pharyngitis	1	1
Rhinitis, acute	1	1
Rhinitis, atrophic	1	7
Sinusitis	4	16
Tonsillitis		10
Tympanic Membrane Perforation	18	87
Tumor, benign, lower lip	1	1
Tumor, middle ear	1	1
Total	56	289
Cardio-Vascular-Renal		
Albuminuria, persistent	18	30
Aneurysm, aortic	1	2
Arythmia		3
Bradycardia		1
Cardiac Hypertrophy	1	3
Cardiac neurosis	1	1
Heart Disease, congenital	3	5
Hypertension	41	89
Nephritis, chronic	4	8
Neurocirculatory asthenia	1	1
Pericarditis		2
Reynaud's Disease		1
Tachycardia, persistent	11	27
Valvular Heart Disease, chronic	7	27
Veins, Varicose	3	8
Total	91	208

	Totals			Totals	
	Mar. '41	Nov. 25, '40- Mar. 31, '41		Mar. '41	Nov. 25, '40- Mar. 31, '41
Pulmonary					
Asthma	3	15	Epispadias		2
Atelectasis		1	Gonorrhea, acute	129	211
Bronchiectasis		1	Hydrocele	1	2
Bronchitis		4	Hypospadias	2	6
Fibrosis of lung, cause not stated		2	Kidney, left—absent	1	1
Hemangioma, chest wall		2	Nephritis, hemorrhagic acute		1
Influenza		2	Orchitis		2
Pertussis		1	Prostatitis, sub-acute		1
Pleurisy, cause not stated		6	Syphilis	8	22
Pleurisy, fibrinous	2	4	Syphilis, tertiary	12	14
Pleurisy, with effusion,			Testicle, atrophy, bilateral		1
ideopathic	1	2	Testicle, undescended	6	19
Pneumonitis, resolving	4	4	Tumor, right breast		1
Pneumothorax, spontaneous		1	Urethritis, chronic, posterior		1
Pulmonary congestion		1	Varicocele	5	11
Pulmonary disease, type not stated		1	Total	171	303
Tuberculosis	27	82	Gastro-Intestinal		
Tumor, mediastinal		1	Appendicitis, acute		1
Tumor, right lung		1	Appendicitis, chronic	1	1
Total	37	131	Colitis, chronic		1
Neurological and Mental					
Alcoholism, acute	2	3	Fistula-in-ano		1
Alcoholism, chronic	8	17	Gastro-enterostomy (post-oper- ative)		1
Amnesia	1	1	Hemorrhoids	4	16
Criminal Record or Criminalism	15	75	Hernia, inguinal	39	70
Dementia Precox	3	3	Hernia, other types	4	10
Emotional Instability		2	Ulcer, gastric or duodenal	1	9
Encephalitis, post	1	3	Total	49	110
Epilepsy	5	7	Orthopedic		
Epilepsy, Jacksonian		1	Arthritis, chronic	3	13
Illiteracy		1	Arthritis, chronic	3	13
Imbecility	2	17	Arthritis, gonorrheal	1	1
Insanity, Maniac Depressive	1	6	Atrophy, muscular, extremities	1	4
Mental Deficiency	2	3	Bursitis, pre-patellar		1
Mental Retardation	1	1	Cellulitis, suppurative		3
Monstrosity of Head		1	Club-foot		1
Morally Unfit		1	Contusion, left foot		1
Moron	1	5	Deformity, skeletal	3	12
Multiple Sclerosis		1	Equinovarus, severe		1
Muscular tremors and incoor- dination, cause not stated		1	Exotosis, right tibia		1
Neurasthenia		3	Fractures:		
Neuritis, severe		1	Lumbar spine		1
Neuro-circulatory neurasthenia		1	Clavicle		1
Neurosis, anxiety	1	2	Finger, compound		1
Neurosis, severe, type not stated		1	Left foot	1	1
Paralysis Agitans	1	3	Genu-Valgus		1
Paralysis, upper lip, C. N. S.		1	Hallux Valgus	1	1
Psychoneurosis	12	36	Ingrowing Toenails	1	2
Psychopathic Constitutional			Knee joint, derangement	1	2
State	7	33	Kyphosis	2	2
Psychosis, unclassified	1	5	Limitation, joint motion	4	10
Sexual Perversion		1	Metatarsalgia		1
Stuttering, stammering, severe		4	Missing Digits, amputation		2
Syphilis, cerebro-spinal	2	3	Osteo-arthritis		2
Cerebral Syndrome, post trau- matic	1	4	Osteomyelitis		1
Total	67	246	Periostitis	1	1
Genito-Urinary					
Adenitis, inguinal	1	2	Pesplanus	6	10
Chancre	1	1	Pilonidal Sinus with Cyst	3	6
Chancroids, preputial		1	Sacroiliac sprain		1
Condylomata of penis	1	1	Scoliosis	5	9
Cystitis, chronic		2	Sprain, ankle		2
Doubtful Wassermann reaction	4	4	Subluxation, recurrent, shoulder	3	3
Enuresis, nocturnal		2	Tuberculosis, left hip		1
			Tumor, bone	1	1
			Wounds, incised or lacerated	3	4
			Total	41	105

	Totals			Totals	
	Mar. '41	Nov. 25, '40- Mar. 31, '41		Mar. '41	Nov. 25, '40- Mar. 31, '41
Metabolic			Miscellaneous		
Diabetes Mellitus		8	Abscess, chronic		1
Froelich's Syndrome, Severe ..		10	Anemia, secondary		1
Glycosuria	1	3	Fever, cause undetermined		3
Gynecomastia	1	1	Juvenile, no parental consent..	1	1
Hyperthyroidism	3	5	Lymphadenopathy	1	1
Obesity	3	4	Physically unfit	-	2
Underweight	3	8	Scarlet Fever, suspect		2
Total	11	39	Scars, deforming from burns ..	1	3
			Mononucleosis, infect.	1	1
Skin			Underheight		1
Acne Vulgaris	1	1	Ulcer, atrophic	2	2
Cellulitis, severe	1	1	Wounds, miscellaneous	-	1
Dermatitis, exfoliative		1	Total	6	19
Furuncle	2	2			
Psoriasis		1			
Epidermophytosis, infected		1			
Total	4	7			

REPORT OF MEDICAL SERVICE ADMINISTRATION

By ELTON W. LANCE, M.D., President, Rahway, N. J.

To the House of Delegates:

Medical Service Administration has progressed slowly, but quite satisfactorily. To date we have developed three plans:

Plan I, a complete plan to cover medical and surgical care for subscribers in their homes, offices of the physicians, and when admitted to the hospital;

Plan II, our so-called catastrophic plan, limited to the payment for medical and surgical care rendered to subscribers while hospitalized; and

Plan III, adapted to the care of low-income farmers who are receiving rehabilitation aid from the Federal Farm Security Administration.

Plans I and II will be placed in operation shortly. The date upon which contracts under these Plans will be effective has been delayed pending final arrangement of administrative matters.

Plan III will be placed in operation as of May 1, with approximately 500 families as subscribers.

There are enrolled, as of April 23, about 2,350 participating physicians. Fifteen counties have now qualified for participation, and we have every hope that the twenty-one counties of New Jersey will have qualified before the Annual Meeting.

We ask that this be considered a preliminary report, as at this critical time in our development we are unable to render a final report for the year.

Respectfully submitted,

ELTON W. LANCE, M.D., *President*
JOHN S. THOMPSON, *Secretary*
AUGUSTUS S. KNIGHT, M.D., *Treasurer*
COL. JOSEPH BIGLEY
EDWARD W. SPRAGUE, M.D.
GEORGE W. MERCK
WILLIAM G. HERRMAN, M.D.
WILLIAM J. CARRINGTON, M.D.
NORMAN M. SCOTT, M.D., *Medical Director*

REPORT OF THE STATE BOARD OF MEDICAL EXAMINERS OF NEW JERSEY

By E. S. HALLINGER, M.D., F.A.C.S., Secretary

To the House of Delegates:

During the period of March 20th, 1940, to March 20th, 1941, the Board examined 229 applicants for a license to practice medicine and surgery. Fifty-three of these applicants were licensed osteopaths who qualified for the examination by submitting evidence of having

completed an acceptable post-graduate course of two years in an approved college, or an acceptable internship of two years in an approved hospital, in accordance with the provisions of Section 45:9-14.1 of the Revised Statutes of New Jersey.

The Board also examined eleven applicants for a license to practice chiropody.

TABLE I—SHOWING NUMBER OF CANDIDATES FOR THE 1940 EXAMINATIONS,
CLASSIFIED AS GRADUATES OF MEDICAL COLLEGES IN THE
UNITED STATES AND FOREIGN COUNTRIES AND
ACCORDING TO CITIZENSHIP

	Citizens	*Non-citizens	Total	Passed	Failed
MEDICAL					
<i>United States</i>					
Graduates of Medical Schools	106		106	104	2
Licensed Osteopaths Who Qualified for a Full License to Practice Medicine and Surgery	53		53	47	6
Canada	2		2	2	0
Italy	31		31	10	21
Austria	4	11	15	7	8
Germany	4	9	13	5	8
Hungary	1	3	4	0	4
Great Britain	5		5	4	1
CHIROPODY					
United States	11		11	9	2
	217	23	240	188	52

* Those who were not citizens submitted Declaration of Intention to become an American citizen and were granted a license valid for six years from Date of Declaration.

One hundred and fifty-four licenses were issued to applicants for endorsement of a license from another state who presented credentials to prove they could meet the requirements for examination that were in force in New Jersey at the time they were examined.

TABLE II—Showing Licentiates by Endorsement
Classified as Graduates of Colleges in the
United States and Foreign Countries

Countries	Total
United States	142
Great Britain	4
Germany	1
Italy	2
Austria	3
Switzerland	1
Canada	1
	154

All credentials covering medical and hospital work submitted to the Board were verified by questionnaires sent to the colleges and hospitals before a license was issued, also licenses issued to applicants in foreign countries that

were submitted by candidates for the examination who were graduates of foreign medical schools, and licenses issued in the United States submitted by applicants for endorsement.

The laws governing the practice of medicine and surgery, osteopathy and chiropractic, do not provide for an annual registration. The Board does not, therefore, know whether the number of licentiates practicing in the State is increasing or decreasing.

TABLE III—Showing Number of Physicians and
Surgeons, Osteopaths and Chiropodists, Endorsed
to Other States, the Number of Licentiates of
Whose Death the Board Received a Record and
the Number of Licenses Revoked.

Physicians—Endorsed to Other States	35
Osteopaths—Endorsed to Other States	5
Chiropodists—Endorsed to Other States . . .	1
Medical License Revoked	1
Midwifery License Revoked	1
Deceased Physicians	83
Deceased Osteopaths	1

This table covers the physicians who died in New York City but does not include those who died in other parts of New York State, nor in other states of the United States, nor does it include the number of physicians who are licensed in other states as well as New Jersey who leave New Jersey to practice in some other state in which they are licensed.

An annual registration would give the Board accurate information in regard to the number of physicians practicing in New Jersey and would enable the licensed physicians to assist the Board in enforcing the law by reporting unlicensed physicians in their vicinity.

The laws governing the practice of chiropody and midwifery do provide for an annual registration and our records show a decrease of three in the number of chiropodists that registered on November 1st, 1940, and a decrease of thirty-one midwives for the same period.

ENFORCEMENT

Petition for reinstatement of one license was granted and two were refused. Petition for termination of suspension of one license was refused.

TABLE IV—Summary of Board's Activities in Enforcing the Laws They Administer

Court Cases—Violation of Medical, Etc., Laws	
Convicted, Pleaded Guilty or Settled	42
Lost, No Appeal	4
Decision Reserved	2
Pending in the Courts	28
	— 76

Hearings Before Board

Medical—License Revoked	1
Midwifery—License Revoked	1
Medical—Petition for Reinstatement Refused	2
Medical—Petition for Termination of Suspension Refused	1
Chiropractic—Petition for Reinstatement Granted	1
	— 6
	82

INVESTIGATIONS

Type of Cases Investigated	No. Investigated	No. Visits
Druggists Practicing Medicine	39	346
Prescribing Herbs, Drugs and Appliances	21	143
Medical Doctors	22	49
Unlicensed Chiropractors	30	120
Chiropractors Exceeding License	10	141
Unlicensed Osteopaths	1	9
Osteopaths, Licensed and Exceeding License	3	14
Chiropodists, Unlicensed and Exceeding License	9	24
Electro-therapists	11	61
Laying-On-of-Hands	4	57
Masseurs and Massage Treatments	24	91
Midwives, Unlicensed, Not Registered and Exceeding License	4	12
Optometrists Exceeding License	1	2
Pathologists Practicing Medicine	2	24
Medical Revocation	3	3
Midwifery Revocation	2	5
Miscellaneous	15	19
	201	1120

Average Number of Visits per Investigation—5.5

REPORT OF THE ATLANTIC COUNTY MEDICAL SOCIETY

By V. EARL JOHNSON, M.D., President, Atlantic City, N. J.

To the House of Delegates:

This component Society has, I feel, made progress on all fronts. We have consistently had scientific programs of interest and excellent scientific value presented by men who are outstanding in their particular subject. The meetings have been very well attended as a whole. Two joint meetings were held this year, one with The Atlantic County Dental Society and one with the Cape May County Medical Society. I believe these joint meetings served a very good purpose.

Of course the outstanding business of our Society this year has been in connection with Medical Preparedness, and in connection with the Medical Service Administration. The Medical Preparedness Program here has been very efficiently handled by the Committee and the Society. The setting up of the Medical Examining Boards was a huge task, but that Committee did a good job. The organization of these Boards for efficient work was made possible by the Atlantic City Hospital, which provided excellent space and personnel (nurses and interns) and equipment. We understand that the work of these Boards in the Atlantic City Hospital facilities is regarded as a model to be copied in other populous areas. Two other Boards meet outside of Atlantic City—one in Pleasantville and one in Mays Landing—to serve those sections conveniently, and their work has been very satisfactory. We appreciate the coöperation we have been given in this work by the hospital and by the non-medical personnel of the various Draft Boards. All but two of the recommendations for the medical personnel of these Boards were accepted by the War Department and by the Governor,—we appreciate this confidence.

The Medical Service Administration has

been unusually well considered by the membership. At the November 8th, 1940, meeting the Society approved the Administration. Following this there was a great deal of group discussion about it and it seemed that too few members actually knew what the plans were all about. On petition, a special meeting was called, when an entire evening was devoted to its discussion, and many plausible arguments were presented. No change in the original approval was made as adjournment was moved before any further motion was entertained. Our Insurance Committee has twice reported its approval of the Medical Service Administration, but so far we have not succeeded in securing 51 per cent of the signatures to the agreement. The Committee is still working on that and it is possible that these signatures may be secured before the publication of this report. We may be criticized in other sections of the State for our reaction to this problem, but I think it represents a very healthy condition in our Society when men will form an opinion and stand up and express themselves about it. Certainly no coercion is being used.

Another business activity of this Society had to do with the telephone listings of Osteopaths under Doctors of Medicine. We claim that it is misleading and misrepresenting. We carried it to the House of Delegates last June and have followed it through the committees and Board of Trustees. This matter is now in the hands of the Board of Trustees.

We have been honored by official visits from President Morris and President-Elect Lewis, and by visits from Dr. Wilkes and Dr. Scott, and Mr. Harty.

Respectfully submitted,
V. E. JOHNSON, President.

REPORT OF THE BERGEN COUNTY MEDICAL SOCIETY

By RUSSELL K. TETHER, M.D., President, Closter, N. J.

To the House of Delegates:

In June, 1940, the Bergen County Medical Society held a public mass meeting in conjunction with the Ladies' Auxiliary. The principal speaker of the evening was Dr. Morris Fishbein, Editor of the Journal of the American

Medical Association. First Dr. Kler gave a summary of the need for medical care as found by the committee appointed by the Governor of the State of New Jersey. Our State President, Dr. Morris, gave a brief introduction of Dr. Fishbein, who spoke on "Socialization of Medi-

cine". The talk was well received by the public.

In the latter part of June a joint meeting was held with the Mayors and Councils, and Boards of Health of Bergen County, and the Bergen County Veterinarian Associations, the Bergen County Medical Society acting as host. As there had been three recent deaths from hydrophobia, methods were discussed as how best to control the spread of rabies. Talks were given by members of the State Departments of Health, National Health Institute and Veterinarians, followed by general discussion from the floor. The conclusion reached was that the State quarantine regulations should be followed to the letter. By showing the interest of the doctor in this epidemic, we feel we created a more coöperative spirit between the general public and their local health departments.

In the early Fall our Medical Preparedness Committee under Dr. Muller, on short order, organized the physicians for draft board work. Not a single physician hesitated to serve when called. The Committee has organized the entire county for disaster. Each hospital with its staff is organized and every physician knows his post in case of an emergency. The Committee has correlated its plans with the police, first-aid units, Red Cross, Public Service and

Telephone Company trained first-aid men, and other interested organizations.

Our regular meetings have been well attended. We have been favored by visits from Dr. Morris, the State President; Dr. Lewis, the First Vice-President, and at our annual banquet Dr. Marsh, Second Vice-President. Our scientific programs have been designed for the general practitioner. Excellent and noted speakers have talked to the members. Among them were Dr. C. Mayo, of Rochester, Minnesota, and Dr. S. Wiess, Professor of Medicine at Harvard Medical School.

Our Executive Committee and Sub-Committees have gravely considered the new problems which are slowly pushing us toward Socialized Medicine. We realize the necessity of close coöperation of our members. A consolidated front must be presented in directing this trend so the type of socialization will be just to the people and the medical profession.

The Medical Service Administration, instituted by the State Medical Society, deserves praise and coöperation from every County Society. It is one of the most beneficial steps for the public and the physician that has been taken in years. There should be more publicity among the physicians.

Respectfully submitted,

RUSSELL K. TETHER, President.

REPORT OF THE BURLINGTON COUNTY MEDICAL SOCIETY

By GEORGE T. TRACY, M.D., President, Beverly, N. J.

To the House of Delegates:

The value of any report, in the final analysis, is based on actual achievements; therefore, it seems appropriate in submitting this account, to comment on some of our accomplishments and mention other activities.

Our Program Committee with Dr. John C. Voss as chairman has rendered excellent service by arranging diversified scientific programs. Well attended meetings with many participating in the discussions is abundant evidence of their popularity. The Moorestown Field Club has proven a rendezvous for many who linger into the late and early hours, appeasing their hunger at our regular buffet supper.

A unique feature of our September meeting was a joint session at Medford Lakes Lodge sponsored by the Burlington County Bar Association and our Society. Our wives and

many distinguished guests were present. Dr. Phillip Levine of Newark made the chief address, taking as his subject "Blood Tests in Paternity Cases". This gala night inaugurated an important event in the history of Burlington County and it is hoped that more functions of this nature will be held in the future.

Concerning Cancer Control, it is regretted the failure of the Burlington County Hospital to coöperate in organizing a cancer clinic has delayed this project one year. However, it is now definitely assured that by April 15th a cancer clinic will be established in the Zurbrugg Hospital at Riverside, with facilities for diagnosis, treatment and follow-up methods. This is made possible from funds collected by the Burlington County Women's Field Army for the Control of Cancer, with the coöperation of the Board of Managers of the Zurbrugg Memorial Hospital at Riverside, and the indefatigable efforts of Dr. Hammell P. Shipp,

Chairman of the Public Health Committee of our Society.

Our Medical Preparedness Committee has formulated a disaster unit nucleus in Burlington which includes the Masonic Home, St. Mary's Guild House, and the U. S. Pipe and Foundry Company, with assurances of their continuing coöperation. The committee is extending its efforts along this line.

Amendments to our Constitution by defining more specifically the duties of the Treasurer has materially assisted in collecting the annual dues. Another amendment to the By-Laws provides for a nominating committee of three, elected from the floor at the annual meeting for a term of three years, with one new member

elected each year. The committee functions during the society year presenting nominations at the annual meeting, which facilitates a more democratic procedure in making nominations.

Our Maternal Welfare Committee continues with its constant supervision of our nursing homes, baby stations and is coöperating in the Tri-County Maternal death rate which continues to remain below the average for the State.

Unfortunately very few members have participated in post-graduate education this year, although it has been available at Camden.

Respectfully submitted,

GEORGE T. TRACY, President.

REPORT OF THE CAMDEN COUNTY MEDICAL SOCIETY

By ROBERT S. GAMON, M.D., President, Camden, N. J.

To the House of Delegates:

The Camden County Medical Society has functioned satisfactorily during the past year, largely as a result of efficient committee work.

Our Defense Committee, through Dr. H. B. Decker, Chairman, endeavored to coöperate and advise with the appointed representatives of the New Jersey State Government in selecting all physicians for draft duty. It organized a Draft Induction Board for the Federal Draft Service. This Board functioned during its one month's existence. The same committee has organized, in conjunction with the local County Red Cross Executives, an emergency set-up for surgical care in catastrophes.

The Maternal Welfare Committee, under Dr. Gordon F. West's leadership, has held regular meetings. Close check has been kept on Maternal Mortality. There is noted an increase in the interest of the physicians doing obstetrics, as shown by the discussions at the well-attended meetings.

Our Membership Committee presented twenty new physicians for membership; eighteen of these have been elected and are now in good standing, two were rejected by ballot. We

have had one resignation and one transfer to another county. One member has been elected to Honorary Membership.

Our meetings have been well attended and the Scientific Committee has provided excellent programs.

The annual Post-Graduate Course is now under way in conjunction with the Gloucester County Medical Society. This course has always been self-sustaining and is quite popular as a "refresher course" in the Spring of the year.

The Society provided an opportunity for the Chairman of the Legislative Committee of the State Society to meet the newly elected members of our county government who serve in the State Legislature.

The Society has had splendid coöperation from the offices of the State Medical Society and is entering into the Medical Service Administration with enthusiasm. Over 51 per cent of the Society's membership has signed the agreement to be participants in the Plan.

Respectfully submitted,

ROBERT S. GAMON, President.

REPORT OF THE CAPE MAY COUNTY MEDICAL SOCIETY

By ALDRICH C. CROWE, M.D., President, Ocean City, N. J.

To the House of Delegates:

The Cape May County Medical Society has had a very successful year. The monthly meetings have been continued as originated last year. The members have continued interest in the scientific work and the attendance at the meetings has been very good.

The scientific subjects have covered a number of fields and were chosen for the primary interest to the general practitioner.

One of the outstanding meetings was the Second Annual Doctors-Lawyers Meeting. Judge Herbert F. Goodrich of the United

States Circuit Court of Appeals, and Dr. Edward A. Strecker, Professor of Psychiatry at the University of Pennsylvania, were the speakers.

Cape May County feels proud of having originated the idea of the combined meeting of the Doctors and Lawyers, and we feel that much benefit has been derived. To the best of our knowledge it is an innovation in the State of New Jersey.

Respectfully submitted,

ALDRICH C. CROWE, President.

REPORT OF THE CUMBERLAND COUNTY MEDICAL SOCIETY

By CHARLES BUTCHER, M.D., President, Heislerville, N. J.

To the House of Delegates:

Cumberland County Medical Society held its regular afternoon meetings and three interim evening meetings, at all of which there was a consistent average attendance. Some of the best programs were presented at the evening meetings and were very well received.

Several new members have been added during the year, and a decidedly increased conciliatory attitude was evidenced by the fact that all were elected unanimously. The opinion seems to have become established that most physicians who are qualified to practice medicine should be members of some component society in organized medicine.

The Cumberland County Medical Society has been represented at most State committee meetings, and it has been felt that the information received was not only first hand, but that it could be more enthusiastically presented to the local group. Representatives have also been

appointed to some of the more active lay organizations, and we feel that by so doing we will be more cognizant of their activities and will be more able to adapt their policies.

A continuation of the cancer, orthopedic, and diabetic clinics has been maintained. Interest in these clinics has been increased by the unstinting service of members of the Society.

In order to cement friendliness with the surrounding societies, the visiting delegates have been recognized in open meetings and the secretaries of their respective societies notified of the delegates in attendance at our meetings.

The records of the Cumberland County Medical Society have been kept intact, and since the value of these records is evident, both to our Society and to the State Society, a fire-proof repository has been obtained in order that these records might be amply protected.

Respectfully submitted,

CHARLES BUTCHER, President.

REPORT OF THE ESSEX COUNTY MEDICAL SOCIETY

By HARRY N. COMANDO, M.D., President, Newark, N. J.

To the House of Delegates:

The past year has been a very active one, probably the most active in the history of the Essex County Medical Society. The program for the year was built around our general meet-

ings and two special meetings, which were under the joint auspices of our Heart and Lung Committees and the Medical Section of the Academy of Medicine of Northern New Jersey. Our programs were as follows:

OCTOBER 10, 1940

"The Prolonged First Stages of Labor"—an illustrated address by Dr. W. E. Caldwell, Professor of Clinical Obstetrics, Columbia University.

NOVEMBER 14, 1940

"Lesions of the Biliary Tract"—an address by Dr. Waltman Walters, Professor of Surgery, University of Minnesota, Graduate School. Illustrated by lantern slides.

DECEMBER 12, 1940

"Factors Affecting Mortality Rates Among Premature Infants"—an illustrated talk by Dr. Oliver L. Stringfield, Assistant Professor of Pediatrics, Columbia University. Program arranged by the Child Welfare Committee.

"Functions of the Executive Office"—an address by Dr. LeRoy A. Wilkes, Executive Officer, Medical Society of New Jersey.

JANUARY 9, 1941

"Medical Preparedness for a Military Emergency"—an address by Brigadier General Shelley Marietta, Assistant Surgeon-General, U. S. Army, Commanding Officer, Walter Reed Hospital.

FEBRUARY 13, 1941

"Etiology, Diagnosis and Treatment of the Anemias"—an illustrated address by Dr. Maurice B. Strauss, Associate Professor of Medicine, Harvard Medical School; Assistant Physician, Thorndike Memorial Laboratory, Boston.

MARCH 13, 1941

"Use of High Frequency Current in Medicine and Surgery"—an illustrated talk by Dr. William H. Schmidt, Assistant Professor of Physical Therapy at Jefferson Medical College, Philadelphia.

APRIL 10, 1941

"Improvements in Diagnosis and Therapy of Diseases of the Lymph Nodes"—an illustrated address by Dr. Francis Carter Wood, Professor of Cancer Research, Columbia University College of Physicians and Surgeons, New York.

SPECIAL MEETINGS

OCTOBER 17, 1940

"The Present Status of Digitalis Therapy"—an illustrated address by Dr. Arthur C. DeGraef, of New York University and Bellevue Hospital. Discussion opened by Dr. Arthur M. Fishberg, of Mt. Sinai Hospital, New York.

Program arranged by the Heart Committee in cooperation with the Medical Section of the Academy of Medicine of Northern New Jersey.

FEBRUARY 11, 1941

"War Wounds and Injuries of the Chest", by Dr. Edward D. Churchill, Professor of Surgery, Harvard Medical School, Boston; and Dr. Charles F. Bove, Former Chief Surgeon, American Hospital in Paris, 1919 to August, 1940.

Program arranged by the Lung Committee in cooperation with the Medical Section of the Academy of Medicine of Northern New Jersey.

PUBLIC MEETINGS

(Conducted by the Public Relations Committee)

January 21, 1941—"Facts About Vitamins", by Dr. Robert S. Goodhart, of New York University College of Medicine.

February 25, 1941—"The Miracle Drugs", by Dr. Joseph J. Bunim, of New York University College of Medicine.

Our educational program was greatly broadened through the splendid accomplishments of our Post-Graduate Instruction Committee. This committee has started an ambitious program of post-graduate courses, given at the Newark City Hospital through an affiliation of the Newark City Hospital with the College of Medicine of New York University. The following courses are being presented:

1. Circulatory Diseases of the Extremities. This course was repeated by request. First period, November-December; second period, January-February.

2. Fractures (all types except head). Practical demonstration of how to apply casts, tractions, etc.

3. Liver and Biliary Diseases.

4. Amputations.

5. Tuberculosis.

6. A Physical Therapy Course, the joint enterprise of the Physical Therapy and Post-Graduate Instruction Committees, has been offered, giving practical physical therapy methods in various conditions, such as neurological, dermatologic, gynecologic, nose and throat, etc.

By far our most active committee is still our Public Relations Committee, which has continued along the same lines as were adopted last year. We can safely say that the relations between the Essex County Medical Society and the public are excellent. Activities were divided into the following classifications; Press and Radio: Our column, "The Story of Modern Medicine", published in the Newark Evening News, terminated in July, 1940, and has been replaced by a new column entitled "Timely Medical Topics", which appears each Saturday. Judging by the number of letters we have received, the public finds this interesting and instructive.

Our Committee still believes that paid advertising in local newspapers or other publications is not a satisfactory method of developing cordial relations with the general public. The only paid advertisements we have placed in the papers are those announcing our general meetings for the laity.

Speakers' Bureau: Speakers on economic subjects have been incorporated this year. This appears to have been advantageous from every

point of view. Dr. R. A. Schaaf, Chairman of the Public Relations Committee, has received many favorable comments regarding the quality of our speakers' addresses and the manner in which they were received.

Exhibits Committee: This Committee has had on display at the Newark Museum the following interesting exhibits:

"How the Clinical Laboratory Fights Disease."

"Your Personal Health."

"Your Child and Its Care."

Motion Pictures: This Committee has been working on an ambitious program to show movies on medical topics in all of the major high schools in the county. The program is well in hand, and concrete results are expected shortly.

The Advisory Committee to the Medical Service Plan has been concerned chiefly with the obtaining of signatures to enable the Plan to function in Essex County. The necessary 51 per cent of Essex County physicians have signed their agreements, so that the Plan can now be put into operation.

On very short notice from the Adjutant General, five days to be exact, 200 volunteers to act as members of the draft boards, the advisory boards and the appeal boards were submitted by the Medical Preparedness Committee. Most of our recommendations were accepted, and I am happy to say the men have done a splendid job. Subsequently this Committee was called upon to supply volunteers for the induction boards and substitutes for all the boards from time to time. They have accomplished these things in a most efficient manner.

The Maternal Welfare Committee has initiated a program of conducting conferences once a month on maternal deaths in Essex County. The quality of these meetings has been excellent. Very valuable discussions have been brought out, and I am sure that all who attended the conferences have benefitted.

The Cancer Committee has been very active and has been working in close harmony with the Cancer Committee of The Medical Society of New Jersey.

The Physical Therapy Committee broadened its activities this year by sponsoring and giving a course of nine lectures, as well as sponsoring the scientific part of the program celebrating our 125th anniversary. On this occasion our members who have been in practice for fifty years or more were honored. We found that we had twenty such members, and despite the fact that the weather was inclement twelve of these men attended the dinner, and those who were unable to do so, chiefly on account of poor health or residence at too great a distance, sent their regrets. All who attended, guests as well as members, agreed that this was a splendid affair. At the general meeting each honored member was presented with a resolution drawn up by Dr. Aaron Parsonnet and presented by Dr. C. R. O'Crowley, which read as follows:

"We, your colleagues and friends in the Essex County Medical Society, join on the occasion of your completion of fifty years of medical practice in conveying to you this expression of our admiration and affectionate regard.

"We sincerely appreciate your untiring efforts on behalf of medicine which have redounded to the best interests of physician and patient. We wish you many years of continued good health and happiness."

The work of the Woman's Auxiliary during the past year is especially commendable. In addition to their own activities, they have participated in the meetings conducted for the laity, and are sponsoring a dinner and dance to be held during Doctors' Week. We sincerely appreciate the help the Auxiliary has given us and are always ready to give us on request.

Respectfully submitted,

HARRY N. COMANDO, President.

REPORT OF THE GLOUCESTER COUNTY MEDICAL SOCIETY

By HENRY B. DIVERTY, M.D., President, Woodbury, N. J.

To the House of Delegates:

The past year has been one of unprecedented activity and interest. The meetings have been well attended and there has been a fine spirit of coöperation among the members.

Our committees are functioning well, particularly the Public Relations Committee, Dr. Louis K. Collins, Chairman, and the newly formed Medical Preparedness Committee, Dr. William W. Pedrick, Chairman.

Although our Society is small, it is gratifying to note the number of our membership who are active on important committees in the State Society. We are proud of the fact that one of our honored members, Dr. Ralph K. Hollinshed, was elected Second Vice-President of the State Society last year.

The required quota of our members has signed as participants in the Medical Service

Administration Plan. We are confident of the success of this Plan. It will demonstrate that the medical profession is capable of administering its own affairs.

We are proud to be a component of the State Medical Society and pledge our continued cooperation and loyalty.

Respectfully submitted,
HENRY B. DIVERTY, President.

REPORT OF THE HUDSON COUNTY MEDICAL SOCIETY

By GEORGE GINSBERG, M.D., President, Hoboken, N. J.

To the House of Delegates:

The Hudson County Medical Society is happy to report the largest paid-up membership for the current year in the history of the Society—469.

The speakers for the monthly meetings were as follows:

Dr. Robert E. Buckley, Surgeon Director, Manhattan Eye, Ear and Throat Hospital, New York, and Consulting Otolaryngologist at Roosevelt Hospital, New York, "Removal of Larynx for Carcinoma".

Dr. LeRoy A. Wilkes, Executive Officer of The Medical Society of New Jersey, "Medical Society Aims and Functions".

Dr. Charles H. Schlichter, Chairman of the State Medical Preparedness Committee, and Dr. Norman M. Scott, Secretary of the State Medical Preparedness Committee, "Medical Preparedness".

Dr. Elliot P. Joslin, Clinical Professor of Medicine, Emeritus, Harvard University Medical School, "The Renaissance of the Treatment of Diabetes".

Dr. Lewis Stevenson, Associate Professor of Neurology, Cornell University Medical College, New York, "Recent Advances in the Diagnosis and Treatment of Diseases of the Nervous System".

Dr. Thomas Cherry, Professor of Gynecology, New York Post-Graduate Medical School and Hospital, "Office Gynecology".

Dr. J. Arthur Myers, Professor of Medicine and Preventive Medicine and Public Health, University of Minnesota, "The General Practitioner's Part in the Program of the Prevention and Control of Tuberculosis".

Dr. Hugo Roesler, Cardiologist, Department of Medicine, Temple University School of Medicine, "As-

pects of Circulatory Disturbances—(a) Venous Pulse; (b) Dizziness and Fainting; (c) The Endocrines".

Symposium on Anesthesia (speakers from Hudson County)

"The Present Status of General Anesthesia", Alex. Povalski, M.D.

"The Present Status of Spinal Anesthesia", John J. O'Shea, M.D.

"Obstetric Anesthesia and Asphyxia Neonatorum", John J. Muccia, M.D.

"Medical Points of Interest in the Choice of Anesthetic Agents", William J. Gleeson, M.D.

"Pre- and Post-Operative Anesthetic Care", Abram P. Blakey, M.D.

The members of both the county and State committees have been active, and these activities have been integrated, whenever possible, with those of the State Medical Society program.

In our monthly meetings we have tried to balance in our programs the proper proportions of the newer scientific advances in medicine, the economics of practice and distribution of medical services and a fair amount of good fellowship which is necessary to insure the knowledge, vitality, mental alertness and confidence which are essential in the successful practice of our profession.

Public Relations work has been handled by our Publicity Committee through addresses to groups, by radio broadcasts, and through the Health Observance Week.

Respectfully submitted,
GEORGE GINSBERG, President.

REPORT OF THE HUNTERDON COUNTY MEDICAL SOCIETY

By IVAN B. SMITH, M.D., President, Dayton, N. J.

To the House of Delegates:

The greatest part of the business of the regular meetings of the Hunterdon County Medical Society was concerned with the current problems of the Selective Service Act, the Medical Preparedness Committee, and the Medical Service Administration.

The response of the members in volunteering their services to assist on the various boards pertaining to the Selective Service problem was very gratifying. A Medical Preparedness Com-

mittee was appointed, which has been active in preparing for any eventuality.

Several visits from members of the State Society and the Medical Service Administration clarified many points in the current problems. The majority of the Society favored supporting the Medical Service Administration.

We sincerely regret the loss of several of our older members.

Respectfully submitted,

IVAN B. SMITH, President.

REPORT OF THE MERCER COUNTY MEDICAL SOCIETY

By HAROLD C. COX, M.D., President, Hightstown, N. J.

To the House of Delegates:

The annual meeting for the election of officers was held in December; therefore, having been accorded the honor of the presidency at the last election held in December, 1940, my tenure of office covers only the months of January, February and March.

The Program Committee has been most fortunate in obtaining speakers of well-known reputation and ability on such subjects as "Medical Service Administration", "Diabetes, from the Standpoint of the General Practitioner", "The Mechanism of the Cardiac Cycle"—subjects which commanded the attention of large audiences at every meeting.

The Committees on Maternal Welfare, Industrial Insurance, Health and Accident Insurance, and Public Relations have exercised the opportunities afforded for advancement in each particular phase of their activity and have obtained results worthy of their undertaking.

Owing to enforced absence in military duty of many of the younger men, the post-grad-

uate lectures have been temporarily discontinued.

The applications for membership continue to indicate an interest in affiliation; its many advantages are recognized to be of paramount value.

There have been so far very few resignations.

The interest in Society meetings is manifested by the large attendance,—a most encouraging feature to the officers, elected to govern the activities.

Perfect harmony and a most sincere and co-operative attitude pervade the entire membership, and the President takes great pleasure in expressing his appreciation of this spirit, demonstrated at the meetings so far held this year.

There appears to be sufficient evidence at this time that full coöperation will obtain throughout the year in the personnel of all committees appointed, for their specific duties.

Respectfully submitted,

HAROLD C. COX, President.

REPORT OF THE MIDDLESEX COUNTY MEDICAL SOCIETY

By R. J. FAULKINGHAM, M.D., President, New Brunswick, N. J.

To the House of Delegates:

The Middlesex County Medical Society has held all the regularly scheduled monthly meetings with a good attendance at each.

Medical Service Administration has been discussed and accepted by a number of the members. Others are still holding this under advisement.

Members of the County Society have given their hearty coöperation in a campaign of popular medical education, especially in supplying speakers to women's organizations and study clubs, and other groups.

The society has promoted a fellowship with the druggists and a meeting was held with them in November, at which time a paper on "The Sulfonamide Group of Drugs" was presented by Dr. R. A. Deno, Assistant Professor of Biological Sciences, Rutgers University, New Jersey College of Pharmacy, Newark. Dr. Ernest Little, Dean of New Jersey College of Pharmacy, and Mr. J. J. McLaughlin also spoke briefly.

The society is promoting a fellowship with

the dentists of Middlesex County, the first meeting to be held in May, 1941.

At the October meeting a committee was appointed to coöperate with the State Society Committee on Medical Preparedness in the county. This committee is functioning wholeheartedly.

A resolution was passed that the Society pay the yearly dues of all members called for a year's extended service in the United States Army.

A part of each meeting is devoted to some scientific subject presented by a speaker, usually from some large hospital or clinic, and the remainder is taken up by the business of the society.

We held a joint meeting of the Woman's Auxiliary of the Medical Society with the regular members of the Society in the form of a dinner dance. We are anticipating a similar meeting in June.

Respectfully submitted,
R. J. FAULKINGHAM, President.

REPORT OF THE MONMOUTH COUNTY MEDICAL SOCIETY

By D. F. FEATHERSTON, M.D., President, Asbury Park, N. J.

To the House of Delegates:

In submitting an annual report upon the activities and progress of the Monmouth County Medical Society, I might first comment on the fact that we have had, I believe, a successful year. There have been no major controversies or problems to settle. Our membership has increased and the unity and accord of our membership has seemed adequate. Our Executive Committee has functioned efficiently, handling all routine business so that the monthly meetings were devoted entirely to scientific discussions.

I believe one of our most successful gatherings, judging from subsequent comments, was a joint meeting of the Monmouth County

Medical Society and the Monmouth County Bar Association. Believing there should be a better understanding between the two professions, a question-and-answer program was arranged for the purpose of discussing mutual problems. The results were very gratifying and I might suggest that other county societies attempt such a program.

I have felt honored in leading our organization for one year, and I wish to express my thanks and appreciation. I also wish to convey my thanks to the officers of The Medical Society of New Jersey for their coöperation.

Respectfully submitted,
D. F. FEATHERSTON, President.

REPORT OF THE MORRIS COUNTY MEDICAL SOCIETY

By W. BLAKE GIBB, M.D., President, Morristown, N. J.

To the House of Delegates:

I beg to report the principal activities of the Medical Society of Morris County for the year 1940-1941.

In September, 1940, I nominated a Preparedness Committee which, in conjunction with the Red Cross, have prepared well-organized plans for taking care of any injured in case of disaster. Also in this month, in conjunction with Dr. B. C. McMahon, Chairman of the Preparedness Committee, names were sent in to the State Society to fill the five draft boards for this county and also eight physicians to serve on the Medical Advisory Board.

In October a regular meeting of the County Medical Society was held at Greystone Park. The principal speaker was Dr. Norman Plummer of New York. His subject was "The Treatment of Pneumonia".

On November 15th a special meeting was held at Greystone Park. This meeting was also well attended and was addressed by Dr. Norman M. Scott on the Medical Service Administration.

The meeting in January, 1941, on diseases of the thyroid gland had to be postponed.

During February, as the county members were in accord with the working of the Medical Service Plan, I designated three physicians and two laymen to act on the County Advisory Board.

We are to have a busy Spring. A post-graduate course of six lectures for the general practitioner is to be given during April and May. A regular medical meeting will be held in April at Dover Hospital on "Fractures", and in May a meeting on "Tuberculosis" will be held at Shongum Sanitarium.

The Bulletin of the Morris County Medical Society is published five or six times during the year to keep the members informed of state and local items of interest. Meetings of the Executive Board have been held during the year to care for any emergencies.

The annual meeting will be held in June and will conclude the year's work.

Respectfully submitted,

W. BLAKE GIBB, President.

REPORT OF THE OCEAN COUNTY MEDICAL SOCIETY

By WILLIAM E. DODD, M.D., President, Beach Haven, N. J.

To the House of Delegates:

The past year has been a trying year for physicians of many communities. Ocean County has had its share of problems to solve. Upon a whole, these have been met and dealt with in an adequate manner.

MEMBERSHIP

There has been one new member added to our ranks during the past year and two young physicians have elected to continue as Junior Members for another year. We have lost four active members this year, two having moved away and two having entered the Army. Active members of the Society in good standing who have entered the military or naval service of the United States have been given their choice of continuing their active membership by paying their dues or being transferred to an honorary status for the duration of their military or naval service. This honorary status does not make them eligible for membership

in The Medical Society of New Jersey or the American Medical Association.

SCIENTIFIC

A variety of programs has been presented during the year ranging from formal papers by distinguished physicians to informal symposiums. One symposium brought together the various welfare organizations of the county, hospital heads and physicians. Another brought together all known organizations within our county having to do with defense and preparedness.

WOMAN'S AUXILIARY

The Society has been greatly pleased to see the undertakings of the Woman's Auxiliary which were begun in previous years and enumerated in last year's report going forward this year with gratifying results. While no new undertakings have been started, definite progress in those already begun has been accomplished.

LADIES' NIGHT

Following its usual custom the Society held its annual dinner dance in honor of the doctors' wives of Ocean County at the Deauville Inn on the evening of March 22nd. The affair was well attended and enjoyed by all. Dr. W. B. Morris, President of The Medical Society of New Jersey, and his wife honored us with their presence and delightful company.

CLINICS

Ocean County Medical Society is convinced more than ever that with a very few exceptions free clinics have no place in our county. Our physicians care for the ambulatory indigent patients willingly and efficiently. We are therefore not confronted with the abuse to which free clinics are so often put in more densely populated communities. The "family doctor", who has all but vanished from some communities, is still a reality in Ocean County.

HOSPITAL RELATIONSHIPS

An effort has been made through the Hospital Relationships Committee to see that there is closer coöperation between the governing bodies and the staffs of our hospitals. Each has been encouraged to study and understand the problems of the other. Three thousand five hundred ninety-two patients have received hospital treatment in Ocean County during the past year.

CANCER COMMITTEE

The Cancer Committee has been active during the year and has worked in close coöperation with the Woman's Field Army for the Control of Cancer. Six public meetings have been addressed by physicians upon the subject of cancer during the past year; and a sound motion picture projector has been purchased in conjunction with the Ocean County Tuberculosis and Health Association so that an educational campaign may be carried forward against cancer as well as against tuberculosis.

LEGISLATION

Through the efforts of our Legislative Keyman our newly elected legislators and representatives of our Society as well as Dr. Fred-eric J. Quigley from the State Society have come to know each other a little more intimately and have frankly discussed our mutual problems.

MATERNAL WELFARE

The Maternal Welfare Committee has been working upon an analysis of the obstetrical problems in our county and is gratified to see a reduction in our death rate for the past year.

MEDICAL PRACTICE

The Medical Practice Committee has assisted one community in obtaining more efficient medical service and has opposed the encroachment of Military Surgeons upon the private practice of civilian physicians.

MEDICAL PREPAREDNESS

The Committee on Medical Preparedness has made every effort to discharge the various duties passed on to it by the State Committee in as efficient and prompt manner as possible. The tasks have been difficult and the committee has received many discouragements brought about by lack of coöperation on the part of individual physicians. On a whole, we feel that it has done a good job.

OTHER COMMITTEES

It is not to be assumed that because other committees have not been especially mentioned that they have not been active. Lack of space prevents me from reviewing them in detail. Thanks of the Society is due the various Advisory Committees, the Committee on the Medical Service Plan, the Speakers' Bureau, the various sub-committees of the Public Health Committee and all others who have done their part in making this year's accomplishments a little nearer the goal to which we aspired.

Respectfully submitted,
WILLIAM E. DODD, President.

REPORT OF THE PASSAIC COUNTY MEDICAL SOCIETY

By FRANK W. ASH, M.D., President, Paterson, N. J.

To the House of Delegates:

This year the Passaic County Medical Society has had as its outstanding objective the plans for medical preparedness. This, with the routine business of the Society, has given us a busy year.

During the Summer we were asked by the State Society to name doctors for the examination of the young men drafted by the government for military service. The doctors were asked to give their services as a patriotic duty and they acquiesced almost unanimously, say-

ing: "You name the place and the time, and I shall be there."

Besides setting up these boards, our Military Preparedness Committee, consisting of Drs. Harold G. Walker, Norman M. Dingman, Louis G. Shapiro, Leon E. De Yoe, Thomas A. Clay, John H. Carlisle, Francis H. Todd and Fred Vosburgh, under the very capable leadership of Dr. John C. McCoy,* has worked out a program for a catastrophic unit in the county. Under their direction, the hospitals of the county have been surveyed to determine the space which could be utilized in each institution in case of an emergency. Through the courtesy of the Red Cross, each hospital has acquired fifty cots with full bedding, with a second reserve supply of 600 additional cots, should they be required. With the idea that the medical direction of an emergency should be directly under the supervision of the county medical society, the committee has created a field unit, consisting of a medical director, an executive staff, with twenty-five physicians in the field unit. This medical field unit is to assume full supervision in directing medical work in such emergency, with the aid of the Red Cross and the nursing profession.

The hospitals have enthusiastically coöperated with the committee. All details such as hospitalization for the injured, dressing supplies, surgical, medical and nursing care, information bureaus, etc., have been assigned to the respective departments of the field unit.

Our Military Relations Committee, consisting of Drs. G. Edward Tuers, Victor F. Desmet, Max Magnes and Alberico Masucci, has met and considered carefully what the relation of the Society and the doctors should be to the doctor leaving for military service. A summary of their report follows:

"In order that those who serve in the armed forces of the country may be properly protected during and after the emergency, the Committee of Military Service Relations makes the following recommendations:

"1. Any physician who is called into service is to arrange with another practitioner to take care of his practice. He is to notify all his patients of this arrangement, informing them of the availability of any records, and suggesting that should the need for a physician arise, they should call upon the relieving doctor.

Further, that monies collected from patients so referred shall be separately placed, and after the deduction of overhead expenses, the remaining fund shall be divided equally; that all such patients so referred shall be returned to the referring doctor upon his return.

"2. Any institution, teaching or industrial appointment held at the time of entrance into military service shall be made available upon the return of the physician, without loss of rights, seniority or privileges.

"3. That a leave of absence be granted all men called to active service from the active membership of the Society, and that a pro rata share of their annual dues be refunded. Further, that such absence shall in no way alter or influence the privileges in participation in the Physicians' Relief Fund."

During the year the county has at last seen established a unit of the Welfare Home for the classification and temporary placement of mental cases. A good deal of the credit for this development should go to Dr. Thomas A. Clay of the County Board of Chosen Freeholders together with the Mental Hygiene Committee of our County Society.

The Pharmaceutical Committee deserves much credit for its preparation of a formulary and also for the good will that has been created between the pharmacists and doctors. These two groups are mutually dependent on one another and anything that can be done to aid each other is commendable.

The Program Committee has given us excellent speakers, many of whom are nationally known. The meetings were held in the auditorium of School 13, Paterson, which the Board of Education gave to the Society for its use. The meeting place was comfortable and there was no parking problem.

The Post-Graduate Committee has again carried on its work in a capable manner. Lectures on carefully selected subjects have been well attended.

Commendation is again in order for the editors of our Bulletin in doing splendid work keeping the membership informed of medical matters in the county.

Respectfully submitted,

FRANK W. ASH, President.

* Deceased.

REPORT OF THE SALEM COUNTY MEDICAL SOCIETY

By WILBUR S. DAVISON, M.D., President, Pennsville, N. J.

To the House of Delegates:

The Salem County Medical Society has held the nine monthly meetings which have been regularly scheduled, including a Spring "shad dinner".

The County Society is coöperating with the County Board of Freeholders in conducting weekly clinics in venereal diseases, held in two centers in the county, at which over 150 patients received regular treatment for syphilis.

The Committee on Medical Preparedness has

obtained data and has outlined a program which can be put into activity within a few hours, if necessary.

Our Society, in conjunction with the Cumberland County Society, is sponsoring a post-graduate course in medicine and surgery.

Other standing committees are reporting progress, in coöperation with the State Society, in Maternal Welfare and in Public Health.

Respectfully submitted,

WILBUR S. DAVISON, President.

REPORT OF THE SOMERSET COUNTY MEDICAL SOCIETY

By J. H. COOPER, M.D., President, East Millstone, N. J.

To the House of Delegates:

This year marks the 125th anniversary of the founding of the Somerset County Medical Society. This assumes particular importance because the Somerset County Medical Society is the oldest medical society in New Jersey.

During the year several important events have occurred in Somerset County, one of the most outstanding having been a symposium of scientific lectures by the men of the Lahey Clinic. Advancement of tuberculosis in the county has taken great strides. Provisions have been made for the purchase of x-ray equipment for the purpose of examining men in

industry and children in schools of the outlying districts of the communities.

Besides the usual course of business and efforts of the Society to improve the relationship between physician and patient, and between physicians themselves, an important scientific meeting was held at the Calco Chemical Co., one of the largest companies of its kind in the country. The members made a tour of the entire plant and an interesting discussion on industrial medicine was held.

Respectfully submitted,

J. H. COOPER, President.

REPORT OF THE SUSSEX COUNTY MEDICAL SOCIETY

By JESSE McCALL, M.D., President, Newton, N. J.

To the House of Delegates:

Over the past few years there has been in evidence in the Sussex County Medical Society meetings a trend of increased interest, coöperation and enthusiasm. The greater problems before the medical profession, and a more intimate contact with the State organization have been prime factors in the creation of this interest and coöperation. The year 1940-41 has seen further development which was productive of meetings filled with clear, if at times prolonged but fruitful discussion and positive action.

Meetings were held in October, 1940, and February and May, 1941. Visitors from the State Society were Drs. LeRoy Wilkes and Norman Scott.

The most important Society activities during the year have been related to the following:

1. MEDICAL PREPAREDNESS

The Medical Preparedness Committee has functioned adequately since its appointment in the Fall of 1940.

2. MEDICAL SERVICE ADMINISTRATION

In October, 1940, the Society approved in principle the plan of Medical Service Administration, and since that time over 51 per cent of Sussex County physicians have enlisted as cooperating members. Active participation in the plan has not yet taken place.

3. OLD-AGE RELIEF

A special committee has, in conjunction with the County Welfare Board, worked out a feasible plan for the care of aged indigents, with an attention to fee schedules and collections, which should aid a great deal in the solution of one of our many minor problems.

4. CONSTITUTION AND BY-LAWS

A revision and modernization of our Constitution and By-Laws has been carried out

during the present year, and without being flagrantly New-Dealish, promises to lend itself more adequately to the proper administration of Society activities in the future.

5. POST-GRADUATE STUDY

A series of six lectures in medicine were available to members of the Society at weekly intervals from April 1 to May 6, 1941. These were arranged through the Committee on Post-Graduate Education, were well attended, and enthusiastically received.

The Society has benefitted by the addition of three new members and has in general enjoyed an active and useful year of existence.

Respectfully submitted,

JESSE McCALL, President.

REPORT OF THE UNION COUNTY MEDICAL SOCIETY

By GEORGE KNAUER, M.D., President, Elizabeth, N. J.

To the House of Delegates:

This past year has been one during which public consciousness has been awakened to the definite need for concerted action on the part of individual groups to recognize and correct problems of social welfare as they appear in local vicinities. This has been demonstrated to our profession as never before in almost every phase of our community life. The need for our medical services has as its close companion the need for our judgment and personal attention to carry out detailed public programs, not merely in the health field but in all fields dealing with public welfare. It is no longer sufficient that the medical profession suggest a possible remedy for the existing welfare problems. The situations are demanding that the profession not only suggest a remedy but that the physicians have adequate contact with private and public agencies so that they may personally see that their suggestions are carried out.

I believe that the best way for us to answer this need is through the work of the County Medical Society committees. During this past year I have found that the most efficient and direct action has resulted from the cooperation in these small groups. This is demonstrated in the work of the Medical Defense Committee. In the past six months the preparedness problem has become increasingly pertinent in this country and this county committee has been responsible for the excellent work done in

helping to establish the Local Examining Boards and the Medical Advisory Board by close cooperation with the Federal and State authorities, and in making a survey in the county to ascertain the available facilities in case of an emergency or military need.

The following results evidence the continuous work of various other committees. The educational program of the Committee on Sight Saving and Hearing has contacted each school nurse and school physician in Union County in the effort to guide the routine examination of eyes and to give correct information to the Parent-Teacher groups as to the great number of eye defects and errors which are amenable to treatment. The efforts of the Maternal Welfare Committee culminated in the first Obstetrical Conference for Union County. An active discussion of maternal deaths for 1940 was carried on by many of the physicians who had attended those cases. The large attendance indicated the widespread interest in maternal welfare.

The Tuberculosis League with the Advisory Committee from the County Society was able to provide a post-graduate course in "Early Diagnostic Aid of Tuberculosis" from April 7th through April 11th. Many of our members were glad to be able to take advantage of this opportunity. The Visiting Nurse Association with the County Society Advisory Committee have revised their rules and regulations

in order to serve most effectively the special needs of their community. The County Welfare Board with its Advisory Committee has attempted to establish adequate health provision for its clients in the simplest manner, allowing the patient to choose his own physician.

The Medical Service Bureau under the Executive Secretary and the Advisory Committee has continued to promote close professional, social and business relationships. Serving on the Board of the Council of Social Agencies and on the Health Committee of the Chamber of Commerce, the Executive Secretary has been able to keep well informed as to various community problems and how these problems are being met. The Executive Office has been established as a clearing house for County Society work, serving as a meeting place for the

committees and coördinating their work. It functions as a medical information bureau and as the editing office of the Bulletin, whose circulation now reaches seven states.

The State Committee which has brought about the Medical Service Administration of New Jersey is to be congratulated on their long and untiring efforts in obtaining this type of medical insurance, and I want to thank Dr. Lance, one of our own members, who has given so freely of his time and effort. Union County Medical Society is glad to be able to support the President of the Medical Service Administration of New Jersey in every possible way and hopes to be one of the first societies to put this plan into effect.

Respectfully submitted,

GEORGE KNAUER, President.

REPORT OF THE WARREN COUNTY MEDICAL SOCIETY

By RALPH BUCHANAN, M.D., President, Phillipsburg, N. J.

To the House of Delegates:

The end of my first term as President of the Warren County Medical Society is growing gradually closer. Warren County Medical Society feels that the year 1940-1941 has been marked by the completion of several outstanding objectives which will of necessity have a noticeable influence upon the practice of medicine in the county for several years to come. All committees have been extremely diligent and active, and the coöperation throughout the Society has been of the best.

CLINICS

Warren County Medical Society has always been instrumental in keeping the county free of clinics, basing this action on the premise that in such a small county it is much more economical and efficacious for indigent ambulatory patients to be cared for free of charge in the offices of the doctors of their own choice.

However, during the year the Society was instrumental in establishing a tumor clinic at the Warren Hospital under the direction of Dr. Roscoe Teahan, a member of Jeanes Hospital Staff, Philadelphia, Pa. This clinic Dr. Teahan faithfully directs twice monthly with good coöperation from the county physicians.

MEMBERSHIP AND ATTENDANCE

During the past year two new members were added to the Society's roster. There were no deaths.

Except for one or two meetings when the weather was inclement, attendance was above the average. However, we have noted with regret the absence of several members who were formerly active in Society work, and sincerely hope that these members will grace our meetings with their presence and advice more frequently.

MATERNAL WELFARE

Warren County physicians had always prided themselves on their low maternal death rate. However, this past year their record has been blemished. To help improve their current record one special meeting was held under the auspices of the Maternal Welfare Committee, with Dr. A. W. Bingham as guest speaker. The practical value of portions of the proceedings was emphasized and was discussed by all members present.

POST-GRADUATE EDUCATION

We feel the need of Post-Graduate Education in Warren County. Due to our limited

number the costs of these courses have kept us from sponsoring our own. However, our most friendly neighbor, Morris County, has always invited us to attend theirs. A goodly number will participate with them in April through May, 1941.

LEGISLATION

Through the Legislative Committee and through direct communications from the Society as a whole, the legislators of Warren County have been contacted on all matters recommended by the State Society.

HARMONY AND CO-OPERATION

"Harmony and Coöperation" has been the motto of Warren County Medical Society, both with the State Society, and within our own organization. The spirit of harmony has prevailed and has made the committee machinery function smoothly and efficiently. The year 1941-1942 holds promise of being more active and progressive. We, of Warren County, pledge coöperation with the State Medical Society, and with the other component societies throughout the State.

Respectfully submitted,
RALPH M. L. BUCHANAN, President.

REFERENCE COMMITTEES

Reference Committee "A" to consider reports of:

The President
The Board of Trustees
The Secretary
Addresses of the President and the President-Elect

David B. Allman, Chairman . . . Atlantic County
J. Allen Yager, Vice-Chairman . . . Passaic
Reeve L. Ballinger . . . Hudson
Adolph Towbin . . . Ocean
Henry B. Orton . . . Essex

Meets Tuesday, May 20, 1941, 8:30 p. m.
I. Tower Room, 13th Floor

Reference Committee "B" to consider reports of:

The Executive Officer
The Publication Committee
The Sub-Committee on Public Relations

Hilton S. Read, Chairman . . . Atlantic County
Frank A. Bien, Vice-Chairman . . . Essex
J. Lawrence Evans . . . Hudson
Emil Stein . . . Union
Robert A. MacKenzie . . . Monmouth

Meets Tuesday, May 20, 1941, 8:30 p. m.
II. Tower Room, 13th Floor

Reference Committee "C" to consider reports of:

The Finance and Budget Committee
The Treasurer
The Medical Service Administration

Royal A. Schaaf, Chairman . . . Essex County
D. Leo Haggerty, Vice-Chairman . . . Mercer
Donald O. Hamblin . . . Somerset
Bernard C. McMahon . . . Morris
Robert E. Watkins . . . Monmouth

Meets Tuesday, May 20, 1941, 8:30 p. m.
Green Room, 13th Floor

Reference Committee "D" to consider reports of:

The Delegates to the A. M. A.
The Medical Preparedness Committee

James F. Norton, Chairman . . . Hudson County
Hammell P. Shipp, Vice-Chairman . . . Burlington

Jacob M. Schildkraut . . . Mercer
David W. Green . . . Salem
Harry Subin . . . Atlantic

Meets Tuesday, May 20, 1941, 8:30 p. m.
III. Tower Room, 13th Floor

Reference Committee "E" to consider reports of:

The Annual Meeting Committee
The Sub-Committee on Scientific Program
The Sub-Committee on Scientific Exhibits
Place and Date of 1942 Annual Meeting

Samuel A. Cosgrove, Chairman . . . Hudson County
Byron G. Sherman, Vice-Chairman . . . Morris
John W. Gray . . . Essex
Cedric C. Carpenter . . . Union
Clarence W. Way . . . Cape May

Meets Tuesday, May 20, 1941, 8:30 p. m.
Room 1367, 13th Floor

Reference Committee "F" to consider reports of:

The Welfare Committee
The Sub-Committee on Legislation

William H. Areson, Chairman . . . Essex County
Frederic W. Lathrop, Vice-Chairman . . . Union
Jesse McCall . . . Sussex
Ralph Buchanan . . . Warren
Baxter A. Livengood . . . Gloucester

Meets Tuesday, May 20, 1941, 8:30 p. m.
Room 1344, 13th Floor

Reference Committee "G" to consider reports of:

The Sub-Committee on Public Health
The Advisory Committees on:

Cancer Control
Venereal Disease Control
Mental Hygiene
Adult Health Supervision
Tuberculosis Control
Child Health
Maternal Welfare
Crippled Children
Pneumonia Control
Traffic Accidents
Conservation of Vision

G. Barton Barlow, Chairman . . . Bergen County
Samuel B. English, Vice-Chairman . . . Hunterdon
Henry Haywood . . . Middlesex
Lorrimer B. Armstrong . . . Union
Vincent Del Duca . . . Camden

Meets Tuesday, May 20, 1941, 8:30 p. m.
Benjamin West Room, 13th Floor

Reference Committee "H" to consider reports of:

The Sub-Committee on Medical Practice

The Advisory Committees on:

Hospital Relationships
Contract Practice
Medical Care of the Indigent
Nursing and Nursing Education
Workmen's Compensation
Auxiliary Medical Services
Pharmaceutical Problems
Industrial Health and Hygiene

Spencer T. Snedecor, Chairman . . . Bergen County
Vincent P. Butler, Vice-Chairman . . . Hudson
F. Clyde Bowers . . . Morris
William A. Tansey . . . Essex
George Knauer . . . Union

Meets Tuesday, May 20, 1941, 8:30 p. m.
Benjamin West Room, 13th Floor

Reference Committee "I" to consider reports of:

The Judicial Councilors

The Medical Defense and Insurance Committee

Harry N. Comando, Chairman . . . Essex County
William F. Jamison, Vice-Chairman . . . Monmouth
Harrison B. Wilson . . . Bergen
Robert S. Gamon . . . Camden
George M. Knowles . . . Bergen

Meets Tuesday, May 20, 1941, 8:30 p. m.
Card Room, Office Floor

Reference Committee "J" to consider reports of:

The Advisory Committee to the Woman's Auxiliary

The County Society Presidents

Daniel F. Featherston, Chm. . . Monmouth County
James H. Mason, Vice-Chairman . . . Atlantic
Charles J. Larkey . . . Hudson

Andrew C. Ruoff . . . Hudson
George F. Dandois . . . Cape May

Meets Tuesday, May 20, 1941, 8:30 p. m.
Room 134, 1st Floor

Reference Committee "K" to consider reports of:

The State Board of Medical Examiners

The Post-Graduate Education Committee

Sigurd W. Johnsen, Chairman . . . Passaic County
William H. Varney, Vice-Chairman . . . Warren
Marcus H. Greifinger . . . Essex
William L. Williamson . . . Hudson
Edward F. Klein . . . Middlesex

Meets Tuesday, May 20, 1941, 8:30 p. m.
Room 136, 1st Floor

I. Credentials

Elias J. Marsh, Chairman . . . Passaic County
Alfred Stahl, ex-officio . . . Essex
George J. Young, ex-officio . . . Morris

Meets each morning at Registration Desk

II. Resolutions and Memorials

Honorary Membership

Wendell J. Burkett, Chm. . . Gloucester Co.
D. Ward Scanlan, Vice-Chairman . . . Atlantic
Herschel Pettit . . . Cape May
Joseph R. Morrow . . . Bergen
Theodore Thompson . . . Ocean

Meets at call of Chairman

III. Constitution and By-Laws

H. Roy Van Ness, Charman . . . Essex County
Robert A. Kilduffe, Vice-Chairman . . . Atlantic
John H. Rowland . . . Middlesex
A. Dunbar Hutchinson . . . Mercer
Frank Ash . . . Passaic

Meets at call of Chairman

IV. Miscellaneous Business

Don B. Weems, Chm. . . Gloucester County
James H. Spencer, Jr., Vice-Chm. . . Sussex
Lawrence G. Beisler . . . Union
J. Irving Fort . . . Essex
Joseph F. Londrigan . . . Hudson

Meets at call of Chairman

NEW JERSEY CHAPTER, AMERICAN COLLEGE OF CHEST PHYSICIANS' BREAKFAST

9:30 A. M., Wednesday, May 21, 1941—Bakewell Room, Haddon Hall

Dr. J. Walton Burge, Chairman of the Board of Regents of the American College of Chest Physicians, will be the speaker.

Tickets for the breakfast may be obtained from Dr. Charles I. Silk, Secretary, 273 State Street, Perth Amboy.

THE 175th ANNUAL MEETING

of

The Medical Society of New Jersey

EXHIBITS:

Scientific—Vernon Room, Lounge Floor
Coöperating Agencies—Vernon Room, Lounge Floor
Educational—Vernon Room, Lounge Floor
Technical—Parlor, Lounge Floor
Art, Hobby and Medical History—Sun Porch, Lounge Floor

Monday, May 19, 1941

- 2:00 p. m.—Registration opens
 All officers, delegates, members of component County Societies, guests, and exhibitors are requested to register at the Registration Desk in the Exhibit Hall on the Lounge Floor, immediately upon arrival.
- 6:30 p. m.—Fellows' Dinner
 Bakewell Room, 1st Floor
- 8:00 p. m.—Board of Trustees' Meeting
 Mandarin Room, 13th Floor
- 8:30 p. m.—Judicial Councilors' Meeting
 Green Room, 13th Floor

Tuesday, May 20, 1941

- 9:00 a. m.—Inspection of Exhibits
- 10:00 a. m.—Woman's Auxiliary, Executive Board Meeting
 Solarium, Lounge Floor
- 10:30 a. m.—House of Delegates
 Garden Room, Lounge Floor
- 2:30 p. m.—General Medical Session—Symposium
 Garden Room, Lounge Floor
- 3:00 p. m.—Rolling Chair Ride for Ladies (no fee)
- 5:00 p. m.—Inspection of Exhibits
- 8:00 p. m.—Reference Committee Meetings
 Reference Committee "A"
 I. Tower Room, 13th Floor
 Reference Committee "B"
 II. Tower Room, 13th Floor
 Reference Committee "C"
 Green Room, 13th Floor
 Reference Committee "D"
 III. Tower Room, 13th Floor
 Reference Committee "E"
 Room 1367, 13th Floor
 Reference Committee "F"
 Room 1344, 13th Floor
 Reference Committee "G"
 Benjamin West Room, 13th Floor
 Reference Committee "H"
 Benjamin West Room, 13th Floor
 Reference Committee "I"
 Card Room, Office Floor
 Reference Committee "J"
 Room 134, 1st Floor
 Reference Committee "K"
 Room 136, 1st Floor
- 8:30 p. m.—Nominating Committee Meeting
 Mandarin Room, 13th Floor

Wednesday, May 21, 1941

- 9:00 a. m.—Inspection of Exhibits
- 9:30 a. m.—Woman's Auxiliary Business Session
 Solarium, Lounge Floor
- 9:30 a. m.—Breakfast, New Jersey Members, American College of Chest Physicians
 Bakewell Room, 1st Floor
- 9:30 a. m.—General Anniversary Meeting
 Garden Room, Lounge Floor
- 12:30 p. m.—House of Delegates (Election)
 Garden Room, Lounge Floor
- 1:00 p. m.—Joint Committee on Professional Relations Luncheon
 Bakewell Room, 1st Floor
- 1:00 p. m.—Jefferson Alumni Luncheon
 Mandarin Room, 13th Floor
- 1:00 p. m.—Woman's Auxiliary Luncheon
 Benjamin West Room, 13th Floor
- 1:00 p. m.—Radiological Society of New Jersey Luncheon
 Tower Room 1337, 13th Floor
- 1:00 p. m.—State Board of Medical Examiners Luncheon
 Tower Room 1333, 13th Floor
- 2:30 p. m.—General Surgical Session—Symposium
 Garden Room, Lounge Floor
- 2:30 p. m.—Woman's Auxiliary Business Session
 Solarium, Lounge Floor
- 4:00 p. m.—Art and Hobby Tea
 Sun Porch, Lounge Floor
- 5:00 p. m.—Inspection of Exhibits
- 7:30 p. m.—President's Banquet
 Rutland Room, 1st Floor
- 10:30 p. m.—Dance
 Rutland Room, 1st Floor

Thursday, May 22, 1941

- 9:00 a. m.—Inspection of Exhibits
- 10:30 a. m.—House of Delegates
 Garden Room, Lounge Floor
- 10:30 a. m.—Woman's Auxiliary Executive Board Meeting
 Solarium, Lounge Floor

GENERAL ANNIVERSARY SESSION

Wednesday Morning, May 21, 1941

Garden Room, Lounge Floor

9:30 A. M.

Prize Essay

"AIMS AND ACTIVITIES RELATED TO HEALTH IMPLICATIONS"

10:10 A. M.

New Jersey State Department of Health
J. Lynn Mahaffey, M.D., Director, Trenton

11:05 A. M.

New Jersey Hospital Association
Ellis L. Smith, M.D., Superintendent, Essex County
Hospital for Contagious Diseases, Belleville

10:30 A. M.

New Jersey State Department of Institutions and
Agencies

William J. Ellis, Commissioner, Trenton
Ellen C. Potter, M.D., Director, Division of Medi-
cine, Trenton

11:25 A. M.

New Jersey State Department of Motor Vehicles
William J. Deardon, Deputy Commissioner, Tren-
ton

11:45 A. M.

New Jersey Tuberculosis League
Berthold S. Pollak, M.D., Medical Director, Hud-
son County Tuberculosis Hospital, Jersey City

10:50 A. M.

New Jersey State Crippled Children Commission
Joseph G. Buch, Chairman, Trenton

12:05-12:25 P. M.

Question-and-Answer Period

GENERAL MEDICAL SESSION

Tuesday Afternoon, May 20, 1941

Garden Room, Lounge Floor

A SYMPOSIUM ON PERIPHERAL VASCULAR DISEASE

2:30 P. M.

1. The Differential Diagnosis and Methods in Per-
ipheral Vascular Disease
Ferdinand C. Ding, M.D., East Orange

3:15 P. M.

4. The Causes and Treatment of Thrombophlebitis
Stuart Z. Hawkes, M.D., Newark

2:45 P. M.

2. The Physical Therapeutic Devices in Treatment
of Peripheral Vascular Disease
B. S. Troedsson, M.D., Orange

3:30 P. M.

5. The Neurogenic Factors in Peripheral Vascular
Disease
Johannes F. Pessel, M.D., Trenton

3:00 P. M.

3. Surgical Procedures in Occlusive Vascular Dis-
ease
Harold Hantman, M.D., Newark

3:45 P. M.

6. A Critical Analysis of the Present Treatment of
Peripheral Vascular Disease
Irving S. Wright, M.D., New York City

4:15 P. M.

Question-and-Answer Period

GENERAL SURGICAL SESSION

Wednesday Afternoon, May 21, 1941

Garden Room, Lounge Floor

A SYMPOSIUM ON ACUTE DISEASES OF THE ABDOMEN

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| <p>2:30 P.M.</p> <p>1. The Proper Technical Approach to a Possible Surgical Abdomen
Robert S. Gamon, M.D., Camden</p> <p>2:45 P.M.</p> <p>2. When Are Duodenal and Gastric Ulcers and Gall-Bladder Diseases Medical and When Are They Surgical?
Manfred Kraemer, M.D., Newark</p> <p>3:00 P.M.</p> <p>3. The Rôle of the General Practitioner in Appendicitis
Royal A. Schaaf, M.D., Newark</p> | <p>3:15 P.M.</p> <p>4. The Differential Diagnosis Between Acute Diseases of the Lower Abdomen and Acute Diseases of the Pelvis
William J. Carrington, M.D., Atlantic City</p> <p>3:30 P.M.</p> <p>5. The Differential Diagnosis Between Acute Diseases of the Chest and Acute Diseases of the Abdomen
George P. Muller, M.D., Philadelphia</p> <p>4:00 P.M.</p> <p>Question-and-Answer Period</p> |
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WOMAN'S AUXILIARY TO THE MEDICAL SOCIETY OF NEW JERSEY

FOURTEENTH ANNUAL MEETING

Program of Events

TUESDAY, MAY 20, 1941

- 9:00 a.m.—Registration—Luncheon Tickets—
Dinner Tickets
Exhibit Hall, Lounge Floor
- 10:00 a.m.—Executive Board Meeting, Mrs. R. J. McDonald, President, presiding
Solarium, Lounge Floor
- 3:00 p.m.—Rolling Chair Ride for Ladies (no fee)
In the event of inclement weather, cards in lieu of Chair Ride.

WEDNESDAY, MAY 21, 1941

- 9:30 a.m.—Business Session. Mrs. R. J. McDonald, President, presiding
Solarium, Lounge Floor
Invocation: Dr. Henry Merle Mellon, First Presbyterian Church, Atlantic City
Address of Welcome: Mrs. Anthony G. Merindino, President, Woman's Auxiliary to the Medical Society of Atlantic County
Response: Mrs. O. R. Carlander, President-Elect
Memorial Services for Departed Members:
Mrs. James R. Hunter, Westville
Reports and Business
- 12:30 p.m.—Adjournment for Luncheon
- 1:00 p.m.—Auxiliary Luncheon honoring Mrs. Richard J. McDonald, president (fee \$2.00)
Benjamin West Room, 13th Floor
Speaker: Watson B. Morris, M.D., President, The Medical Society of New Jersey
Entertainment: Impersonator, Miss Islay Bensen. Music—Trio
Presentation of President's Pin:
To: Mrs. Richard J. McDonald
By: Mrs. A. Haines Lippincott

- 2:30 p.m.—Business Session continued
Solarium, Lounge Floor
- 4:00 p.m.—Art and Hobby Tea
Sun Porch, Lounge Floor
- 7:30 p.m.—Banquet honoring Dr. Watson B. Morris (fee \$3.00)
Rutland Room, 1st Floor
Hostesses: Auxiliary to The Medical Society of New Jersey
Toastmaster: Dr. William J. Carrington, Atlantic City
Welcome: Mrs. Richard J. McDonald, President, Woman's Auxiliary
Dr. Watson B. Morris, President, The Medical Society of New Jersey
Introductions: Mrs. Oswald R. Carlander, President-Elect, Woman's Auxiliary
Dr. Thomas K. Lewis, President-Elect, The Medical Society of New Jersey
Presentation of Fellow's Key:
To: Dr. Watson B. Morris, President
By: Dr. E. Zeh Hawkes, Junior Past-President
Oration: One Hundred and Seventy-five Years of Medicine in New Jersey (illustrated)
Dr. Watson B. Morris, President
Entertainment: Lee Rogers, Troubadour
- 10:30 p.m.—Dance
Rutland Room, First Floor
Orchestra: Alex Bartha

THURSDAY, MAY 22, 1941

- 10:30 a.m.—New Executive Board Meeting, Mrs. O. R. Carlander presiding
Solarium, Lounge Floor

SCIENTIFIC EXHIBITS

ARRANGED BY THE SUB-COMMITTEE TO THE STANDING COMMITTEE ON THE
ANNUAL MEETING

WILLIAM W. HERSOHN, M.D., Chairman, Atlantic City, N. J.

(The numbers refer to the booths)

EXHIBITS OF CO-OPERATING AGENCIES

Vernon Room, Lounge Floor

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| 5
Activities of the New Jersey Department of Institutions and Agencies

State Department of Institutions and Agencies, Trenton, N. J. | 7
Activities of the New Jersey Department of Motor Vehicles
State Department of Motor Vehicles, Trenton, N. J. |
| 6
Activities of the New Jersey Department of Health
State Department of Health, Trenton, N. J. | 8
Activities of the New Jersey Tuberculosis League
New Jersey Tuberculosis League, Inc., Newark, N. J. |
| | 9
Activities of the New Jersey Hospital Association
New Jersey Hospital Association |
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EDUCATIONAL EXHIBITS

Vernon Room, Lounge Floor

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| 1
The Mechanism of Contraception
New Jersey Birth Control League, Newark, N. J. | 35
Selective Sterilization for Human Betterment
Sterilization League of New Jersey, Princeton, N. J. |
| 2
Telling the World—How Your Public Relations Committee Works
Committee on Public Relations of The Medical Society of New Jersey | 36
Maternal Mortality Statistics in New Jersey
The Committee on Maternal Welfare of The Medical Society of New Jersey |
| 4
New Jersey Formulary Preparations
Joint Committee on Professional Relations of The Medical Society of New Jersey and the New Jersey Pharmaceutical Association | 37
Committee on Medical Preparedness of The Medical Society of New Jersey

Pavillion |
| 10
Activities of a Pathologist in a Community
American Society of Clinical Pathologists, Muncie, Ind. | Library Exhibit
Academy of Medicine of Northern New Jersey, Newark, N. J. |
| 30
Registry of Medical Technologists
American Society of Clinical Pathologists, Muncie, Ind. | Pavillion
Child Welfare in Essex County
Child Welfare Committee of Essex County Medical Society, Newark, N. J. |

SCIENTIFIC EXHIBITS

Vernon Room, Lounge Floor

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| <p style="text-align: center;">3</p> <p>The Industrial Physician in National Defense
New Jersey Association of Industrial Physicians
and Surgeons</p> <p style="text-align: center;">11-12</p> <p>Primary Cancer of the Lung—A Radiologic Study
Raphael Pomeranz, M.D., and R. H. Dieffenbach,
M.D., Newark, N. J.</p> <p style="text-align: center;">13</p> <p>Classification and Treatment of Carcinoma of Breast
Milton Friedman, M.D.; Benjamin Copleman,
M.D., Newark City Hospital, Newark, N. J.</p> <p style="text-align: center;">14</p> <p>Gastroscopy
Eugene Merliss, M.D., Newark Beth Israel Hos-
pital, Newark, N. J.</p> <p style="text-align: center;">15</p> <p>Endocrine Lesions and Experimental Cretinism
Samuel A. Goldberg, M.D., Presbyterian Hospital,
Newark, N. J.</p> <p style="text-align: center;">16</p> <p>Plastic Surgery of Nose and Face
Samuel Cohen, M.D., Philadelphia, Pa.</p> <p style="text-align: center;">17</p> <p>Acidosis and Alkalosis—Clinical Measurement and
Significance
W. G. Exton, M.D., and A. R. Rose, Prudential
Insurance Company of America, Newark, N. J.</p> <p style="text-align: center;">18</p> <p>Plastic and Reconstructive Surgery of the Head,
Neck and Extremities
Jacques W. Maliniac, M.D., Sydenham Hospital,
New York City, and Beth Israel Hospital, New-
ark, N. J.</p> <p style="text-align: center;">19</p> <p>Osteogenic Sarcoma
Thomas A. Shallow, M.D.; Kenneth E. Fry, M.D.,
and Ned T. Raker, M.D., Jefferson Hospital,
Philadelphia, Pa.</p> <p style="text-align: center;">20</p> <p>Esophageal Orifice Hernia — A Clinical-Roentgen
Study
Louis L. Perkel, M.D., Jersey City Medical Center,
Jersey City, N. J.</p> <p style="text-align: center;">21</p> <p>The Blood Bank—Two Years of Successful Opera-
tion
William Antopol, M.D.; Lester M. Goldman, M.D.;
Philip Levine, M.D.; M. Ashkenazy, M.D.; H.
Sprinz, M.D., Newark Beth Israel Hospital,
Newark, N. J.</p> | <p style="text-align: center;">22</p> <p>Toxicity of Sulfanilamide Derivatives and Organic
Lesions Caused by Their Administration
William Antopol, M.D.; Lester M. Goldman, M.D.;
H. Sprinz, M.D.; Jacob Churg, M.D.; D. Lehr,
M.D.; M. Klein, M.D., Newark Beth Israel Hos-
pital, Newark, N. J.</p> <p style="text-align: center;">23</p> <p>Puerperal Sepsis
Nicholas M. Alter, M.D., Margaret Hague Mater-
nity Hospital, Jersey City, N. J.</p> <p style="text-align: center;">24</p> <p>Surgery of the Anorectum—Special Reference to
the Avoidance of Pain
Harry E. Bacon, M.D., and Reginald A. Archam-
bault, M.D., Temple University and University
of Pennsylvania Graduate Schools of Medicine,
Philadelphia, Pa.</p> <p style="text-align: center;">25</p> <p>Uses and Misuses of Estrogens nad Androgens
Rita S. Finkler, M.D., and Associates, Beth Israel
Hospital, Newark, N. J.</p> <p style="text-align: center;">26</p> <p>Plastic and Reconstructive Surgery
Morton I. Berson, M.D., New York City</p> <p style="text-align: center;">27</p> <p>Cystoscopic Photography
Lowrain E. McCrea, M.D., Temple University
Medical School, Philadelphia, Pa.</p> <p style="text-align: center;">28</p> <p>Plastic Surgery
Julius Newman, M.D., Newark, N. J.</p> <p style="text-align: center;">29</p> <p>The Fungi: Their Rôle in Respiratory Disease
Nathan Schaffer, M.D., and Irving L. Applebaum,
M.D., Newark Beth Israel Hospital, Newark,
N. J.</p> <p style="text-align: center;">31</p> <p>Hip and Pelvis—Non-traumatic Roentgen Pathology
Raphael Pomeranz, M.D., Hospital for Crippled
Children, Newark, N. J.</p> <p style="text-align: center;">32</p> <p>Proctoscopic Views—Lesions of the Rectum and Sig-
moid
Benjamin Haskell, M.D., and Louis K. Collins,
M.D., Jefferson Medical College Hospital, Phila-
delphia, Pa.</p> <p style="text-align: center;">33-34</p> <p>Diabetes in the 1940's
Elliott P. Joslin, M.D.; Louis I. Dublin, Ph.D.,
George F. Baker Clinic of the New England
Deaconess Hospital, Boston, Mass., and Metro-
politan Life Insurance Company, New York City</p> |
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To Our Members:

Technical exhibitors need concrete evidence of your personal interest in their exhibits. Please register at their booths in order to demonstrate that it pays to exhibit at the Annual Meeting of The Medical Society of New Jersey. Our income from these exhibits pays a large part of the cost of our Annual Meeting. Aside from this, you yourself will benefit from visiting each of them.

ANNUAL MEETING COMMITTEE.

TECHNICAL EXHIBITS

Booth 1—Sharp & Dohme, Inc., Philadelphia, Pa., will have their new modern display this year, featuring "Delvinal" Sodium, "Lyovac" BeeVenom Solution, and other "Lyovac" biologicals. There will also be on display a group of new biological and pharmaceutical specialties prepared by this house, such as "Propadrine" Hydrochloride products, "Rabellon", "Padrophyl", "Riona", "Depropanex" and "Ribothiron". Capable, well-informed representatives will be on hand to welcome all visitors and furnish information on Sharp & Dohme products.

Booth 2—Burrroughs Wellcome & Co. (USA), Inc., New York, N. Y., presents a representative group of fine chemicals and pharmaceutical preparations, together with new and important therapeutic agents of special interest to the medical profession.

Booth 3—Schering Corporation, Bloomfield, N. J.—ORETON, the most potent androgenic hormone known to medicine; ORETON-M Tablets for *orally effective* male and hormone therapy; PRANONE, the orally effective corpus luteum preparation—in fact, all the highly advanced Schering hormones are on display at the Schering exhibit, which is practically a survey of recent endocrine progress. In addition, there are some other particularly interesting products such as LUDOZAN tablets, the physiologically ideal antacid, and BARAVIT, the new bulk-plus-vitamin technic for the treatment of chronic constipation. Members of the Medical Research Division will be present and welcome discussion of problems. Representatives attending: Dr. William H. Stoner, C. P. Silirie and R. H. Pietrzycki.

Booth 4—Lepel High Frequency Labs., Inc., New York, N. Y., announce a change in distribution. Reinhold Schumann, Inc., of Newark, Bellevue Surgical Supply Co. of Passaic and Service Surgical Co. of Paterson have the complete line of Lepel equipment on their showroom floors and are well qualified to render any service on the various Lepel apparatus. Lepel again calls attention to their new ultra short-wave apparatus in addition to its deluxe Model TC, ultra violet lamps, low volt genera-

tors, and their well-recognized spark gap short wave generators. You are cordially invited to visit their booth.

Booths 5 & 6—Mead Johnson & Company, Evansville, Indiana—"Servamus Fidem" means We Are Keeping the Faith. Almost every physician thinks of Mead Johnson & Company as the maker of Dextri-Maltose, Pablum, Oleum Percomorphum and other infant diet materials. But not all physicians are aware of the many helpful services this progressive company offers physicians. A visit to Booths 5 and 6 will be time well spent.

Booth 7—Smith, Kline & French Laboratories, Philadelphia, Pa.—At Booth 7 the medical specialties of the Smith, Kline and French Laboratories, Philadelphia, are on display. The display is arranged in such a way as to tell a brief story of each product. However, a representative in attendance welcomes the opportunity to go into further detail and answer any questions.

Booth 8—The Mennen Company, Newark, N. J., will exhibit their two baby products—Antiseptic Oil and Antiseptic Borated Powder. The Antiseptic Oil is now being used routinely by more than 90 per cent of the hospitals that are important in maternity work. Be sure to register at the Mennen exhibit and receive your kit containing demonstration sizes of their shaving and after-shave products; also, for the lucky number prize drawing to be held at the close of the Convention for DeLuxe Fitted Leather Toilet Kit.

Booth 9—Davies, Rose & Company, Limited, Boston, Mass.—Again Davies, Rose & Company, Limited, of Boston is pleased to have the opportunity of inviting the members to visit its Booth 9 at the Technical Exhibit of the Annual Meeting. There they can become further acquainted with its laboratory productions, which include clinically tested and accepted therapies for the various branches of medicine. The more recent of this firm's specialties is Tablets of Guanidine Hydro-

chloride, in which form the hygroscopic interference encountered with the plain salt is overcome, permitting of easy and effective administration. Mr. F. L. Moulton, well known to many of the members, will be at the booth to welcome you.

Booth 10—C. B. Fleet Co., Inc., Lynchburg, Virginia, will display *Phospho-Soda (Fleet)*, which is a highly concentrated and purified, aqueous solution of sodium phosphates. It is non-toxic, rapid but mild in action without irritation of the gastric or intestinal mucosa. It is indicated for hepatic dysfunction, and for its thorough eliminating and cleansing action on the upper and lower gut.

Booth 11—The Alkalol Company, Taunton, Mass. (1896-1941), is this year completing 45 years of service to the medical profession. The company manufactures two famous preparations: 1, *Alkalol*—a scientifically balanced alkaline saline solution containing no glycerine and barely a trace of alcohol. It is hypotonic and a mucus solvent. 2, *Irrigol*—an alkaline, saline douche powder which makes a non-toxic, slightly astringent solution, useful as a vaginal douche, rectal enema and for colonic irrigations.

Booth 12—H. J. Heinz Co., Pittsburgh, Pa.—The makers of Heinz Strained and Junior Foods appreciate the confidence which the members of The Medical Society of New Jersey have expressed in their recommendation of these foods for infant feeding and special diets. Some of these foods are on display as well as various literature—newest of which is the ninth edition of the Nutritional Chart, and Nutritional Observatory. The Heinz representatives are at your service and will welcome members and friends at the exhibit.

Booth 13—The Borden Company, New York, N. Y.—Visit Booth 13 to learn about Borden's new Prescription Product for vaginal therapy—Betanal Vaginal Capsules, whose four-point action helps restore normal vaginal defenses. Also exhibited are infant foods of unsurpassed quality—Biolac, the distinctive new liquid infant food; Beta Lactose, Dryco, Klim, Merrell-Soule Products, and Irradiated Evaporated Milk.

Booth 14—Jones Metabolism Equipment Co., New York, N. Y., invites you to see the original waterless metabolism apparatus. The exclusive features of the Jones include a double slope tracing which eliminates the possibility of technical errors; a simplified and accurate slide rule for calculations, and the life-time guarantee of accuracy greater than 99 per cent. The 20 years of experience of the Jones Metabolism Equipment Company have made it possible for them to produce a fool-proof, simple and accurate machine.

Booth 15—Ciba Pharmaceutical Products, Inc., Summit, N. J.—Physicians are cordially invited to visit Booth 15 where Ciba will have on display their well-known specialties including Coramine, Nupercainal, Nuporal, Digifoline, Trasetin Vioform, etc. The latest information concerning Perandren, Di-Ovocycin, and other gynecogenic preparations will be available, together with literature describing their clinical application where androgenic and estrogenic therapy is indicated. Their latest product of interest in the field of hormones is Metandren, chemically pure methyl testosterone and orally active androgen. Representatives of the firm will be in attendance and will be glad to answer any questions in regard to the products displayed.

Booth 16—Cook Laboratories, Inc., New York, N. Y.—Featuring Novocain solutions combined with the vasoconstrictor Cobefrin for local anesthesia in tonsillectomies. The speed and safety of the cartridge system of injection and the readily perceptible advantages of Cobefrin in reducing systemic reactions to a minimum are making Novocain solutions with Cobefrin, in 5 cc. Cook "Carpule" cartridges, essential in any modern armamentarium. Mr. Winterbaum will be present to explain in detail the mechanical features of the cartridge system, outline the drugs available and to demonstrate 1 cc. cartridge outfits and medicaments which fill at last every requirement for parental medication in emergency cases.

Booth 17—The Coca-Cola Company, Atlanta, Georgia—Coca-Cola will be served complimentary, at Booth 17, to the Delegates and Members of The Medical Society of New Jersey and their guests and friends.

Booth 18—Nestle's Milk Products, Inc., New York, N. Y.—The exhibit of Nestle's Milk Products, Inc., in Booth 18, features Lactogen, which has given successful results in infant feeding for more than 15 years.

Booth 19—Holland-Rantos Co., Inc., New York, N. Y.—Modern contraceptive technic will be graphically illustrated with a motion picture, and all the various contraceptive materials including both the Koromex and Hyva diaphragms, Koromex and H-R Emulsion Jelly, together with the most complete line of contraceptive specialties, will be demonstrated at the booth of the Holland-Rantos Company. Be sure to call for samples and instructive literature.

Booth 20—Reed & Carnrick, Jersey City, N. J., pioneers in endocrine therapy for over eighty years, have striven to go forward step by step with the advance of scientific medicine. In addition to Estrogenic Hormones R & C, which is triple assayed, economical and packaged in four important

strengths (including Tablets Estrogenic Hormones R & C for oral administration), they respectfully call to your attention a new line of ampules, important among which are Vitamin B₁ Liver Extract, Calcium Gluconate and B₁ Liver and Iron.

Booth 21—The Sun Rayed Company (Division of Kemp Brothers Packing Co.), Frankfort, Indiana, producers of Kemp's Sun-Ray Brand Tomato Juice. The natural, pasteurized juice of a carefully bred strain of Indiana Tomatoes, sun-ripened on the vines and U. S. Government graded. The whole, carefully cored tomato is converted into juice by Kemp's patented process No. 1746657, which utilizes all the tender solids, insuring smooth, full-bodied consistency and rich red nonseparating color. Provides an excellent source of vitamins A and C and a good source of vitamin B-1. Samples served at the booth. Representative in charge: Frederick J. Nixon of Seggerman Nixon Corp., sales representative, New York City.

Booth 22—The Liebel-Flarsheim Company, Cincinnati, Ohio, extends an invitation to you to visit Booth 22 for a demonstration of short wave equipment, rated by users as the most flexible, most accurately controlled and economically priced units on the market today. The famous Bovie Electro-Surgical Units and other new and interesting electro-medical apparatus will also be on display. Look us up and see this L-F equipment.

Booth 23—Faulhaber & Heard, Inc., Newark, N. J.—Any member who desires information in connection with professional liability protection, a feature of membership, can obtain full particulars at Booth 23, maintained by Faulhaber & Heard, Inc., the official Broker of The Medical Society of New Jersey. Ninety per cent of the members have taken advantage of this contract. This is evidence of the benefits derived by having their protection in the company that has served the Medical Society since 1921.

Booth 24—National Casualty Company, Jersey City, N. J.—The State Medical Society's endorsed Physician's Special Policy of Accident and Health Insurance continues to be the most widely endorsed accident and health policy for physicians in the metropolitan area. Individual accident and health policies are issued to eligible physicians and surgeons up to the age limit of 65, from \$100.00 monthly to \$300.00 monthly benefits, with or without accidental death indemnity and hospital residence expense and nurse's service. For the literature and information regarding this policy, stop at Booth 24 in charge of E. & W. Blanksteen, 76 Montgomery Street, Jersey City, N. J., who are the Society's authorized accident and health insurance representatives.

Booth 25—The Harrower Laboratory, Inc., Glendale, Calif., will again be represented at the Annual Meeting of The Medical Society of New Jersey where they will exhibit their complete line of high quality endocrine products. Their New Jersey representative, Mr. H. M. Schulenberger, will anticipate meeting his friends at booth, which is 25.

Booth 26—Cameron Surgical Specialty Co., Chicago, Ill.—See the new Cameron-Schindler Flexible Gastroscope, the Color-Flash Clinical Camera, the Projectoray, the Mirrolite and latest developments in electrically lighted Diagnostic and Operating instruments for all parts of the body. Of special interest will be the new inexpensive office model Radio Knife, Combination Spark Gas & Tube Electro-Surgical Unit, and other Electro-Surgical Units for cutting, coagulating, desiccation, fulguration and ultra-violet therapy in all sizes from the office model to the hospital unit with an abundance of power for the most radical surgery and trans-urethral prostatic resections.

Booth 27—Lederle Laboratories, Inc., New York City, are featuring their Hay Fever Products and the Tuberculin Patch Test (Vollmer) Lederle, Vi-Ferrin, Tetanus Toxoid, the new improved Staphylococcus Toxoid Digent-Modified and Vitamin B Complex. Another feature of the Lederle display will be a large transparency showing their Research and Production Laboratories at Pearl River from the air, with a description of the various units. Regular Lederle staff attendants will be on hand for discussion with the doctors.

Booth 28—John Wyeth & Brother, Inc., Philadelphia, Pa.—You are cordially invited to visit Booth 28 where John Wyeth & Brother will exhibit the following pharmaceutical specialties: Amphojel-Wyeth's Alumina gel for the management of peptic ulcer and hyperacidity. Wyeth's Hydrated Alumina Tablets—for the control of hyperacidity. A-B-M-C Ointment—for the relief of arthritic pain. Alulotion-Ammoniated Mercury with Kaolin—for impetigo. Bepron-Wyeth's Beef Liver with iron—for the nutritional anemias. Bewon Elixir—the palatable appetite stimulant. Buterra-Wyeth's vaginal lotion of Kaolina and Alumina. Kaomagma-Wyeth's Magma of Alumina and Kaolin—for the control of diarrhea and colitis. Mucara—a bulk producing laxative.

Booth 29—Eli Lilly and Company, Indianapolis, Indiana, will demonstrate the germicidal efficacy of "Merthiolate" (Sodium Ethyl Mercuri Thiosalicylate, Lilly) and the compatibility of the antiseptic with body cells and fluids. Other new and useful products will be featured.

Booth 30—Philip Morris & Co., Ltd., Inc., New York City, will demonstrate the method by which

it was found that Philip Morris Cigarettes, in which diethylene glycol is used as the hygroscopic agent, are less irritating than other cigarettes. Their representative will be happy to discuss researches on this subject, and problems on the physiological effects of smoking.

Booth 31—Gerber Products Company, Fremont, Michigan.—The complete line of Gerber Baby Foods will be on display—Dry, Pre-Cooked Cereal Food, fifteen strained foods and ten junior foods. Booklets available for distribution to mothers or patients on special diets as well as professional literature will be sent to registrants for examination.

Booths 32 & 33—Merck & Co., Inc., Rahway, N. J.—The exhibit of Merck & Co., Inc., includes interesting information on the following chemotherapeutic agents: *Sulfapyridine* in pneumococcal infections; *Sulfathiazole* in pneumococcal pneumonia and staphylococcal infections; *Tryparsamide* Merck for neurosyphilis; *Vinethene*, an inhalation anesthetic for short operative procedures; *Pyridium* for urogenital infections; *Mecholyl* for chronic ulcers, Raynaud's disease; and *Vitamins*.

The seventh edition of THE MERCK MANUAL is now off the press. Orders may be placed at the Merck booth, where Mr. S. A. Gaffney will be in charge.

Booth 34—The C. V. Mosby Co., St. Louis, Missouri.—Physicians and surgeons interested in the new developments in medicine and surgery are cordially invited to inspect the new Mosby publications which will be on display in the Mosby Booth 34. Among the new and recent volumes will be: The new third edition of Meakin's "Practice of Medicine"; the new seventh edition of Clendening-Hashinger "Methods of Treatment"; Willius-Keys "Cardiac Classics"; the new ninth edition of Bard "Macleod's Physiology in Modern Medicine"; Nygaard "Hemorrhagic Diseases"; Crossen "Foreign Bodies Left in the Abdomen"; Volume III of Duke-Elder "Textbook of Ophthalmology"; Snell "Medico-legal Ophthalmology"; Schaub and Foley "Methods of Diagnostic Bacteriology"; Rosenthal "Diseases of the Digestive System"; Harris "Clinical Pellagra"; Sutton "Introduction to Dermatology"; and the "Mask of Sanity" by Cleckly.

Booth 35—The Doho Chemical Corporation, New York City.—*Animated Pathological Ear Exhibit*—The Auralgan Exhibit consists of a model of the human auricle four feet high together with a series of twenty-four three dimensional ear drums, modelled under the supervision of outstanding otologists. Each of these drums depicts a different pathologic condition based upon actual case observation and is prepared, insofar as possible, with strict scientific accuracy so as to be highly instructive and interesting to all physicians.

Booth 36—The Muller Laboratories, Baltimore, Maryland.—Mull-Soy will be displayed by The Muller Laboratories at Booth 36. The many advantages of the use of this soy bean milk-substitute in the diets of those persons who are allergic to cow's milk will be explained—as well as the other uses for this interesting product.

Booth 37—J. E. Hanger, Inc., of N. Y., New York City.—This year J. E. Hanger, Inc., celebrates their 80th anniversary. The latest type artificial limbs will be on display showing the most important improvements in modern designs and lightweight limbs, both in duralumin metal and willow wood construction. Booklets will be distributed on amputations from the standpoint of successful prosthesis.

Booth 38—Petrolagar Laboratories, Inc., Chicago, Ill., offers in addition to samples of the Five Types of Petrolagar an interesting selection of descriptive literature and anatomical charts. Ask the Petrolagar representative to show you the *Habit Time* booklet. It is a welcome aid for teaching bowel regularity to your patients.

Booth 39—Parke, Davis & Company, Detroit, Michigan.—Featured in the Parke-Davis Exhibit will be the sex hormones, Theelin and Theelol; antisiphilitic agents, such as Mapharsen and Thio-Bismol; posterior lobe preparations, including Pituitrin, Pitocin and Pitressin; and various Adrenalin Chloride Preparations.

Booth 40—The Chas. H. Phillips Chemical Co., New York City.—"*Phillips' Milk of Magnesia*" (liquid and tablet forms) and "*Haley's M-O*"—standards in the field of alkaline laxative therapy—will feature the exhibit of The Chas. H. Phillips Chemical Co. Visitors are invited to visit Booth 40 to receive samples of these famous products.

Booth 41—Lea & Febiger, Philadelphia, Pa., will exhibit among their new works Kraines' *Neuroses and Psychoses*, Portis on *Digestive Diseases*, Anderson's *Physical Diagnosis*, Lewin on *The Foot and Ankle*, Rony's *Obesity and Leanness*, Adair's *Obstetrics and Gynecology* and Dennie and Pakula on *Congenital Syphilis*. New editions will be shown of Peter's *Extra-ocular Muscles*, Joslin's *Diabetes*, Fishberg's *Heart Failure*, Cushny's *Pharmacology and Therapeutics*, Hadens *Hematology*, Hawes and Stones *Tuberculosis*, Stimson's *Common Contagious Diseases*, Comroe's *Arthritis* and other new works and new editions.

Booth 42—Hanovia Chemical & Mfg. Company, Newark, N. J.—A complete line of the new self-lighting ultra-violet quartz lamps will be on display. Don't fail to ask for a demonstration of the

new air-cooled Kromayer Lamp that completely revolutionizes the previous principles of operation. A complete line of sollux Radiant Heat Lamps and Short Wave equipment will also be displayed. Courteous and competent representatives will be on hand to greet you.

Booth 43—Picker X-Ray Corporation, Newark, N. J.—Visitors to the Picker X-Ray Corporation's booth will have an opportunity of seeing the well-known Picker-Waite "Century". This diagnostic unit provides for radiography and fluoroscopy in all positions from the vertical to the Trendelenberg. The table may be either hand or motor operated, and the table has an optional equipment—a two-position spot film attachment for instantaneous radiography during fluoroscopy. There will also be on display a number of newly developed x-ray accessories and diagnostic opaque chemicals.

Booth 44—Doak Company, Inc., Cleveland, Ohio, pioneers in colloidal chemistry, exhibit the original colloidal sulfur (Sulfur Diasporal) as reported in treatment of chronic arthritis; also specializes in a number of nationally known dermatological preparations: True colloidal sulfur lotion (Lotio Alsulfa) for treatment of acne, Colloidal Sulfur Cream (Sulfur Diasporal Cream) for seborrhea, Tersus (soapless detergent), specially for cases of soap dermatitis, also Original Heliobrom Lotion and Heliobrom powder as used in pruritus. Samples and literature are available.

Booth 45—White Laboratories, Inc., Newark, N. J.—Within recent years tremendous advances in vitamin research have added a wealth of clinical data to our knowledge of nutrition. The intense interest of the laity, in the vitamins—often, unfortunately, confused and misled by unauthoritative lay advertising and uninformed "information"—can be properly controlled by the physician's interpretation of the actual usefulness of the vitamins to his patients. In Booth 45, White Laboratories, Inc., presents its complete line of ethically promoted, clinically reputable vitamin preparations. Qualified representatives are in attendance to discuss with

you the use of White's products in vitamin prophylaxis and therapy. Descriptive literature is available for your review.

Booth 46—The Wander Company, Chicago, Illinois.—During the convention when you feel tired and "let down" have a refreshing cup of Ovaltine at The Wander Company exhibit. Ovaltine is a food supplement enriched in vitamin and mineral content. Feel free to visit the Ovaltine booth often.

Booth 47—E. R. Squibb & Sons, New York, N. Y.—A number of new and interesting Vitamin, Glandular, Biological and Chemotherapeutic specialties will be featured in the Squibb Exhibit in Booth 47. Well-informed Squibb representatives will be on hand to welcome you and to furnish any information desired on the products displayed.

Booth 48—Wallace & Tiernan Products, Inc., Belleville, N. J.—Azochloramid, a Council Accepted, uniquely stable, chlorine bactericide, is effective against all types of microorganisms. This non-toxic, virtually non-irritating medication gradually and uniformly liberates active chlorine, even in the presence of such organic matter as serum, pus, necrotic tissue or fecal material. In addition, Azochloramid is powerfully deodorizing. It will not stain tissue or clothing. Prolonged efficacy reduces the number of applications required, greatly reducing trauma and insuring economy of dressing material and nursing time. Simplicity of use and the ease and speed with which dressings may be prepared make Azochloramid an ideal and economical prophylactic and germicidal agent for hospital and office use.

Booth 49—Kalak Water Co. of New York, Inc., New York, N. Y.—If you are interested in inhibiting the distressing side effects associated with the administration of sulfonamides, salicylates, iodides, arsenicals, etc., drop around to the Kalak Water Co. at Booth 49. While enjoying a refreshing drink of this crystal-clear, sparkling water, ask the representative how Kalak Water may be employed to buffer the untoward effects of these drugs.

THE PRESIDENT'S FINAL REPORT TO THE WELFARE COMMITTEE

*Mr. Chairman and Members of the
Committee:*

At the 1940 Annual Meeting our House of Delegates dedicated itself to four main objectives:

Administrative
Economic
Legislative
Educational

At that time this program seemed rather elaborate because of the demands made upon us in trying to solve the problems involved in the Voluntary Health Insurance Plan, and that of aiding in Medical Preparedness. However, a brief review of the year's work reveals the fact that, in spite of this additional load, many worthwhile things have been accomplished.

ADMINISTRATIVE

The *Administrative* objectives have largely been accomplished. A survey of the State shows that with the momentary exception of two of the smaller counties the activities have run concurrently with those of the State Society, with the result that the Executive Offices have been better able to aid in solving many problems which heretofore caused much unnecessary confusion and expense.

This plan has undoubtedly also been to the advantage of the County Societies, for their reports indicate better organization, more efficiency and greater economy than in former years. It has also been noted that the membership in the counties has steadily increased during the past year and that some of the men who had formerly been affiliated and whose membership, for some reason or other, had lapsed, have rejoined their respective County Societies.

Councilor meetings have been held in various Districts of the State and have been well attended.

ECONOMIC

The *Economic* objectives have met with success throughout the entire State. We all realize the many pitfalls encountered by the committee appointed to study a plan to take care of the low-wage group, and it is gratifying to know that after a period of three years enabling legislation has been passed which will offer a means of giving to this large number of people

in this economic group good medical care to be paid for on an insurance fee basis. I feel that the present lack of universal approval of this plan is due to the fact that it is not yet understood by many persons and never has been read by others.

A careful study of the Act and the Constitution and By-Laws will reveal the advantages that accrue to the physicians and patients who participate in the plan, which includes many persons now being cared for without a fee. Under this plan the physician will receive some remuneration, even if not full fee, for services he renders.

The fact is that this venture was created by the Society and approved by the House of Delegates, and deserves our whole-hearted support. We must also realize that the plans are being continued for one year on an experimental basis, and that during this period the Administration is being financed through funds appropriated by The Medical Society of New Jersey, and the results will be, in part, in proportion to the support it receives in the hands of the members. Another important consideration is that, if successful, these plans will prove that we, as physicians, are capable of solving our own medical and administrative problems, and will stand out as a challenge to State Medicine. If they fail, this will create in the minds of those who want governmental control, a real argument in favor of others taking over the practice of medicine on a national scale. History of other nations where government has intervened shows that this step has never been rescinded.

LEGISLATIVE

The *Legislative* objectives have been unified throughout the State. Most of the counties have adopted the plan of holding informal meetings with their Legislators, at which time prolonged legislation has freely been discussed. In every instance the majority of these men and women in the Legislature who represent us in Trenton have shown intense interest in health, and have promised full consideration of any proposed laws which directly or indirectly affect the practice of medicine.

Our State and County Legislative Committees have consulted with many of the allied professions who contribute to our success in this field.

EDUCATIONAL

The *Educational* objectives have been the basis of some of the outstanding activities of the year.

The Annual Clinical Conference provided a fine opportunity for the members to observe and study the modern methods in diagnosis and treatment carried out in up-to-date hospitals.

Refresher courses have been in progress in many of the counties.

Now that two or more County Societies cooperate, excellent programs can be offered at a small fee, and they are proving very popular.

Other special features have been inaugurated this year. Some of the County Tuberculosis Institutions have provided splendid courses in diagnosis and in treatment of this disease, and they have provided speakers of national reputation to discuss this problem.

Staff Conferences have been held regularly in many of the hospitals but could provide greater advantages to non-staff members of the community if given greater publicity.

For some unknown reason the announcement by the State Society of an award of one hundred dollars and the privilege of presenting an original essay before the Annual Session, seemed to attract inadequate attention. This is surprising, for the plan has proven very attractive to the members of other State Societies.

The inference might suggest that we in New Jersey are reluctant to demonstrate our literary ability, or that we are, at present, too busy taking care of the sick to spend the necessary time in preparing a thesis.

The Regional Conference of representatives of neighboring State Medical Societies, as proposed in my inaugural address, was of necessity omitted this year. It was found that the

demands made upon the time of the officers of the adjoining states, especially those of National Defense, were such as to preclude this year any attempt to create such an organization; but I feel it should have the consideration of the Society at some future time.

This Medical Defense program has made it necessary to omit some of the other activities which were anticipated at the beginning of the fiscal year. However, where better could we as a profession have indicated definitely our willingness and desire to demonstrate our loyalty to the State and Nation?

All credit is due to the State and county committees in arranging for the needed personnel. To the individual members who have and are still giving of their time and effort credit is also due for the way in which they have carried out the exacting examinations of draftees in order that Uncle Sam shall have only healthy individuals serving where needed in the National Defense program.

It is gratifying to learn from reliable sources that New Jersey is among the leaders in meeting the medical professional needs of National Defense, in spite of the fact that the Government we serve holds us convicted as "carrying on in restraint of trade". We shall, however, never be deterred from carrying on the traditions we have followed for many years, and of which we may be justly proud.

As this is the closing session of the Welfare Committee for the fiscal year, may I express my appreciation and gratitude for your splendid coöperation shown by all of the committee, for without the fine spirit that exists in our Society much that has been undertaken would not have been accomplished.

WATSON B. MORRIS, M.D.,

President.

A MESSAGE FROM THE PRESIDENT OF THE WOMAN'S AUXILIARY

Are you a member of the Auxiliary to your County Medical Society?

If the answer is yes, congratulations are in order. If the answer is no, I am sorry, for you are the loser.

You may reply, "Why should I join another organization? I belong to too many already. With the Parent-Teacher's Association, the Woman's Club, the Guilds or Societies in my Church, the Y. W. C. A., the Red Cross, the bridge club and college club, and several other organizations I have more than I can manage. These are all so worthwhile I guess the Auxiliary will not miss me."

The answers sound plausible, but as a member of a doctor's family it is an obligation that you join the Medical Auxiliary in your county.

Let us first look at the word *organization*. The word means "a vitally or systematic organic whole; an association or society". Now we shall look at the meaning of the word *Auxiliary*, and from these two definitions we shall see the reason for our existence and the necessity of one hundred per cent enrollment. *Auxiliary*, applied to our needs, means "a group who assists". It is readily seen that we of the Auxiliary are a society or group who assists—specifically we assist the medical profession.

To be efficient as an Auxiliary, we, as the members of physicians' families, should affiliate ourselves first of all with the County Medical Society. In this way we can do much to protect the best interests of the medical profession. This is not an altogether altruistic reason for belonging to the group, but rather a very practical and material reason.

It is not enough to become a member and pay dues. To make the joining effective, we must attend the meetings, take part in the work of the various committees and so become acquainted with the work and with members of other doctors' families in the community. This is a reason sufficient to warrant our being; for it puts into practice one of our aims, "To foster a friendly relationship among the members of doctors' families."

When we become members of committees we begin to learn much about legislation, public relations and philanthropic work as they apply to a medical man's family. We have great opportunities to become intimately and (most important) correctly informed upon such topics as state medicine, medical legislation and others, about which it is absolutely necessary that we have proper information so that when at the bridge table with someone who tries to tell his friends just how such and such a plan will make medical care so cheap we, as informed women, will be able quietly and effectively to set our misguided or misinformed friends on the right path.

You, as an interested Auxiliary member, can see that properly qualified speakers on medical topics are given an opportunity to be heard in the P.-T. A. groups, the church societies and other organizations. The public will absorb correct information as well as incorrect if we are alert and see to it that authoritative speakers are placed before these groups. This is a great service to the public, to the doctor, and to yourself, because you will be helping to disseminate authentic material from the proper sources. If all the women in the State would consider this matter seriously it would not be long before our membership would be doubled and every county would have an Auxiliary.

So that "He who runs may read", I wish to add a word to the doctors. Perhaps someone will glance at this article and see a word for the medical man. As a member of a County Medical Society, when you have in your county a task to do which requires time, thought and conscientious assistance, remember that standing by, anxiously waiting to help, is the Auxiliary to your County Society. Call upon the Auxiliary and give the members work to do for you. They will be happy to help and to serve you. Give them the opportunity.

ISABEL M. McDONALD, President,
Woman's Auxiliary.

MEMBERS NOW SERVING WITH THE UNITED STATES ARMED FORCES

Alexander, Stewart F., Park Ridge
Alpren, Bernard F., Paterson
Angelo, Joseph A., Secaucus
Angioletti, Louis V., Fort Lee
Balogh, William A., Dunellen
Bar, Samuel, Englishtown
Barone, Francis A., Jersey City
Bayne, Joseph K., Princeton
Bernardini, Odinno, Oradell
Betcher, Albert M., Jersey City
Beyer, William, Englewood
Bolton, Bernard, Newark
Brignola, Gerald C., Hoboken
Brown, Leonard, Ridgfield Park
Carbone, Ralph, Wood-Ridge
Chernus, Jack, Newark
Christian, Henry A., Jersey City
Citta, J. Philip, Toms River
Clunan, Ambrose, Trenton
Cohen, William, Trenton
Corson, Kenneth E., Vineland
Cotton, Henry A., Jr., Trenton
Cox, William T. R., Elizabeth
Cunningham, Charles, Vineland
Cupaiuoli, Richard A., West New York
DeFusco, G. Thomas, Jersey City
DeGrace, Francis H., Passaic
Del Negro, Albert E., Newark
Dembinski, T. Henry, Trenton
Denbo, Elic A., Camden
DeMichele, Roland V., Newark
Diener, Samuel, Newark
Dimun, John T., Trenton
Elias, Elmer J., Trenton
English, Harrison F., III, Trenton
Epstein, William M., Newark
Evans, J. Lawrence, Jr., Leonia
Fine, Sydney G., Trenton
Finkelstein, Herman, Roseland
Fishbein, Elliot, Paterson
Flicker, David J., Kearny
Franzoni, Andrew E., Trenton
Frazee, William H., Jr., Toms River
Freeman, Ray M., Linden
Friedenthal, Bernard, New Brunswick
Gadek, Stanley A., Perth Amboy
Gelb, Jerome, Newark
Gessner, Gerard R., Highland Park
Gidding, Samuel S., Wildwood
Gilbertson, Robert L., Morristown
Gillis, Alfred G., Clayton
Gladstone, Albert L., Paramus
Goldsmith, Alfred S., North Bergen
Goldstein, Joseph D., Jersey City
Goodman, Kenneth, East Orange
Greenfield, Herbert, Newark
Greifinger, William, Irvington
Groeschel, August H., Sussex
Guidotti, Frank P., Trenton
Halpern, William, Woodbine
Heminway, Norman L., Somerville
Hudson, Howard S., Mays Landing
Irwin, Fred, Englewood
Iancone, John A., Paterson
Ivory, Harry S., Point Pleasant
Jacobs, William, Newark
James, J. Thomas, Princeton

Jennings, Edward, Cape May Court House
Joy, Ernest H., Toms River
Koplin, A. Herman, Trenton
Kraut, Arthur M., Jersey City
Kuite, George B., Morris Plains
Kwint, Joseph A., Plainfield
Levine, David B., Paterson
Lilien, Milton, Newark
Magnes, Max, Paterson
Maisel, Irving, Newark
Maldeis, Albertos M. K., Camden
Marrocco, William A., Paterson
McCarthy, William P., Trenton
Meinhard, Fred, Newark
Metz, Henry, Hackensack
Meyers, Francis R., Paterson
Michelson, Henry, Paterson
Miller, George M., Carteret
Monaloy, Morris A., Clifton
Morris, Carlyle, Metuchen
Nadler, Arthur A., Plainfield
Neiman, Watson E., Point Pleasant
Novello, Joseph A., Elizabeth
Oransky, Marvin, Newark
Orris, Harold J., Hillside
Palmer, Francis R., Passaic
Paris, William, Paterson
Pasternack, Elroy, Passaic
Pattysen, Ralph A., East Orange
Pepe, Salvatore, Trenton
Pieper, Howard C., Long Branch
Pierson, Joseph R., Hopewell
Pink, Solomon H., Butler
Pino, Anthony, Bridgeton
Pollock, Franklyn J., Newark
Protzman, Thomas B., Englewood
Rauschenbach, Paul E., Jr., Paterson
Riffin, Irving M., Upper Montclair
Ross, Selig J., Allendale
Samuel, Jerome H., Newark
Satulsky, Emanuel M., Elizabeth
Schachter, Harry A. H., Newark
Schlossbach, Theodore, Ocean Grove
Schmidt, Albert F., Manasquan
Schwartz, Harold, East Orange
Schwartz, Leon, Bridgeton
Shipman, Meyer P., Paterson
Silver, George A., Jr., Hightstown
Simpson, David B., Bayonne
Smith, Arthur B. R., Jersey City
Smith, Edward C., Lakewood
Smith, Percy L., Dayton
Sobin, Julius, Newark
Sommer, George N. J., Jr., Trenton
Spirito, Michael W., Elizabeth
Storaci, Frank S., Trenton
Taber, Frederick S., Highland Park
Tell, M. Edward, Passaic
Tomlins, Francis J., Ridgewood
Walsh, Thomas J., Trenton
Wayman, Bernard R., Trenton
Weltchek, Herbert, Elizabeth
Wentzell, J. Earl, Wenonah
Wilson, Lester R., Camden
Wolowitz, Harry B., Hackensack
Yachnin, Samuel C., Lyndhurst
Yeager, Leslie A., Trenton

SUPPLEMENTARY LIST OF MEMBERS NO. 1

to the

Official List of Members, March 15, 1941

The figures in parenthesis refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

ACTIVE MEMBERS

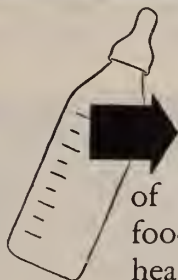
- Asbell, Nathan, 326 Cooper st., Camden (4)
 Avidan, Maurice S., 30 Stratford pl., Newark (7)
 Bender, Dorothea A., 61 DeHart pl., Elizabeth (20)
 Bengelsdorf, Aron, 29 Clinton pl., Newark (7)
 Bennett, Robert E., N. J. State Hosp., Trenton (11)
 Bono, Joseph G., Paris av., Northvale (2)
 Boyd, John B., 141 Broad st., Red Bank (13)
 Brodtkin, Henry A., 365 Osborne ter., Newark (7)
 Brooke, Charles R., 50 Thomas st., Newark (7)
 Calasibetta, Chas. J., 37 Longfellow av., Newark (7)
 Castaldo, Neil, 103 Lincoln av., E., Cranford (20)
 Cooper, Howard M., 37 Ridge rd., Rutherford (2)
 Coppoletta, Jos. M., 452 Palisade av., Palisade P'k (2)
 Crankshaw, Orrin F., 1 Euclid av., Summit (20)
 Craster, Charles V., Plane & Williams st., Newark (7)
 D'Agostini, Robert J., 304 W. Market st., Newark (7)
 Danzis, Louis, 94 Lyons av., Newark (7)
 Denholtz, Emanuel, 16 Harrison pl., Irvington (7)
 Devlin, Arthur D., 617 Broadway, Newark (7)
 Duckett, Warren J., 21 Carlton av., Jersey City (9)
 Dyer, Edward H., 102 S. Victoria av., Ventnor (1)
 Elwell, Alfred M., 407 Cooper st., Camden (4)
 Evans, Edgar E., 12 Ziegler Tract, P'nnsg'r'v'e, Sal'm (18)
 Ewing, Leslie H., 10 Broad st., Berlin (4)
 Farley, Raymond F., Clinton (10)
 Fink, A. Elston, 489 High st., Newark (7)
 Fischer, Edward J., 29 Ashwood ter., W. Orange (7)
 Fisher, Percy C., 145 Franklin av., Ridgewood (2)
 Franc, Donald G., 314 Stuyvesant av., Lyndhurst (7)
 Freeman, Richard D., 103 Scotland rd., S. Orange (7)
 Friedburg, George H., 1108 Anna st., Elizabeth (20)
 Friedrich, Adam H., 424 Lafayette st., Newark (7)
 Gadek, William V., 495 State st., Perth Amboy (12)
 Garrison, George H., Cooper Hospital, Camden (4)
 Gatti, Joseph D., 285 State st., Hackensack (2)
 Gerne, Timothy A., 972 Summit av., Jersey City (9)
 Giordano, William C., 855 Broad av., Ridgefield (2)
 Glass, Harry L., 1009 Park av., Plainfield (20)
 Good, Richard, 949 Park av., Union City (9)
 Gordon, A. Julius, 351 Roseville av., Newark (7)
 Gordon, Sarah, 327 Cedar lane, Teaneck (2)
 Hammett, Lee J., 760 N. 27th st., Camden (4)
 Hasney, Frederick A., 292 Main st., W. Orange (7)
 Heil, Alva A., Milford (10)
 Heyman, Jacob, 55 Oxford st., Newark (7)
 Higgins, Thomas, 146 Reid st., Elizabeth (20)
 Hubach, M. F., Jr., 307 Montg'm'ry st., Bl'mfield (7)
 Hudson, Howard S., 34 E. Main st., Mays Landing (1)
 Imhoff, John G., 913 Summit av., Jersey City (9)
 Irvin, John S., 1910 Pacific av., Atlantic City (1)
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 Jones, Edward C., 183 Grove st., Montclair (7)
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1. Knight, F., and Shelanski, H. A., "Treatment of Acute Anterior Urethritis with Silver Picrate," *Am. J. Syph., Gon. & Ven. Dis.*, 23, 201 (March), 1939.

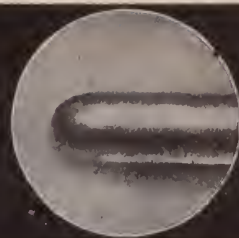
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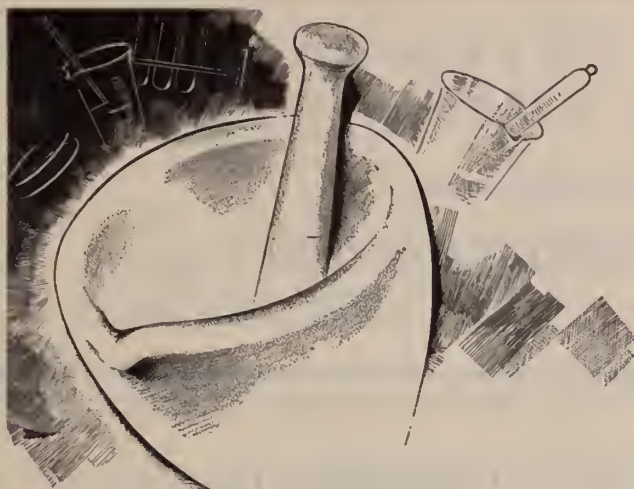
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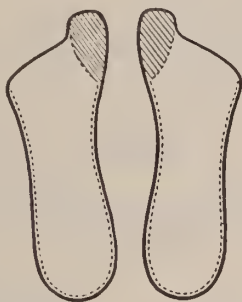
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¹ARCH. PED., SEPT. 1937

Formula—Whole wheat meal • Oatmeal • Yellow corn meal
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brewers' yeast • Malt • 1% table salt for flavoring

PACKAGES: 1 pound and ½ pound.

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*Cerevim has been clinically marketed on a three-year trial basis on the Atlantic seaboard by Cerevim Products Corporation with increasing encouragement from leading pediatricians; hereafter Cerevim will be made and sold by Lederle Laboratories, Inc.





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*Petrolagar—The trademark of Petrolagar Laboratories, Inc., brand emulsion of mineral oil . . . Liquid petrolatum 65 cc, emulsified with 0.4 gm. agar in menstruum to make 100 cc.



Mead's Cereal was introduced in 1930, and Pablum in 1932, by Mead Johnson & Company. Since then, the growing literature indicates early recognition and continued acceptance of these products and the important pioneer principles they represent.

THE JOURNAL

OF THE MEDICAL SOCIETY OF NEW JERSEY

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OF MEDICINE

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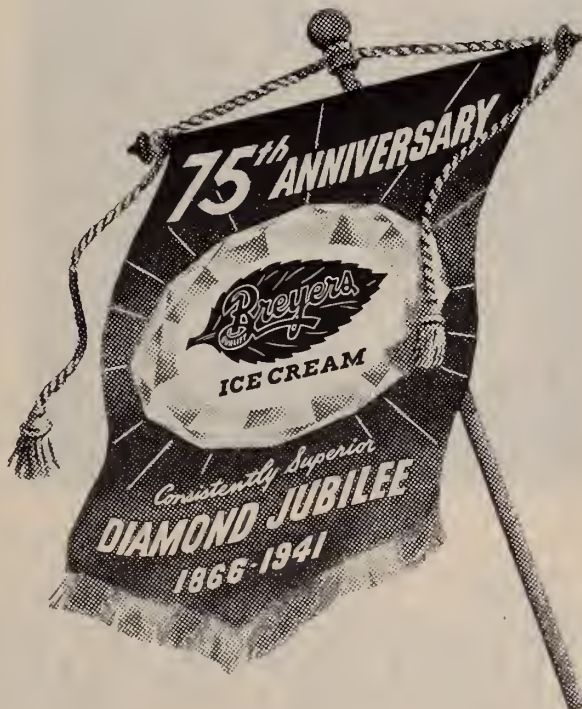
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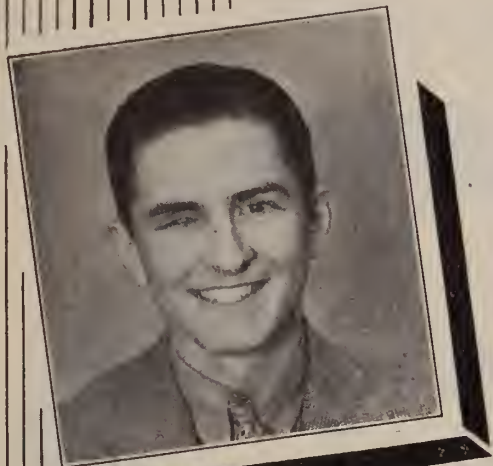
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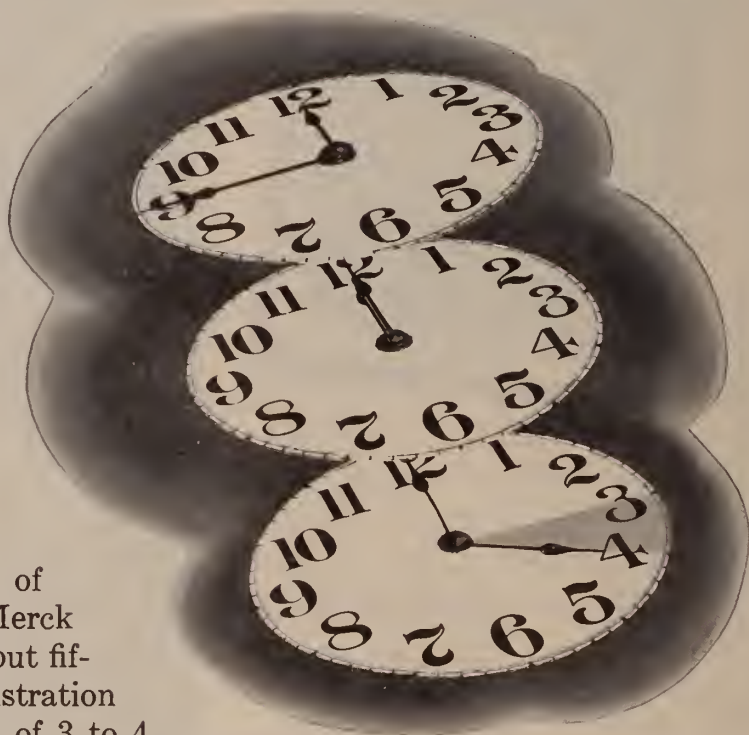
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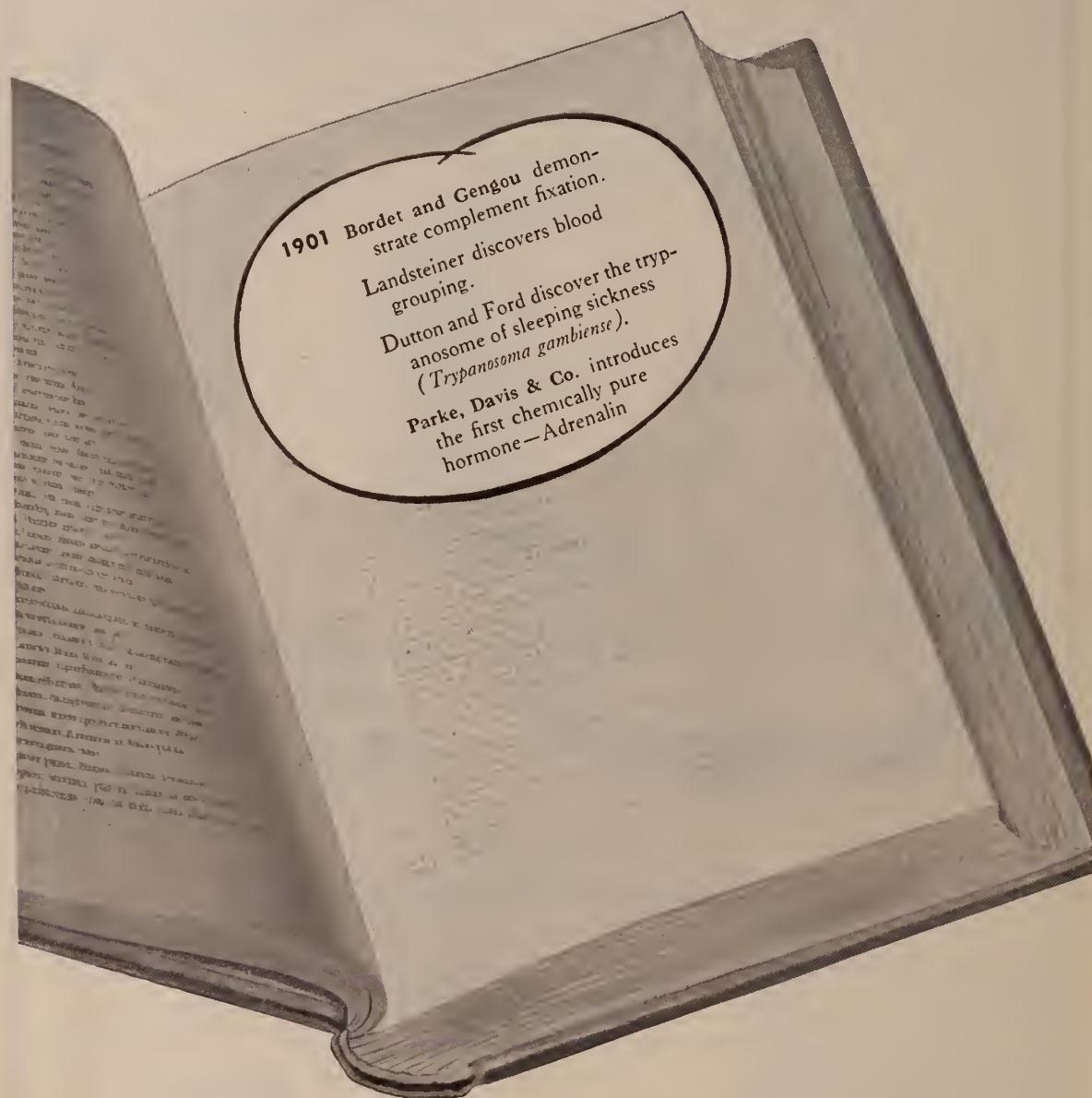
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*Facts from: Proc. Soc. Exp. Biol. & Med., 1934, 32, 241-245; N. Y. State Jrl. of Med. Vol. 35, No. 11,590; Arch. of Otolaryngology, Mar. 1936, Vol. 23, No. 3,306

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Lithium chlorid	21.07	64.49	46.43
Potass. chlorid	361.91	789.54	714.86
Sodium chlorid	2,010.48	8,594.84	4,233.14
Potass. bromid	9.23	160.00	13.90
Potass. iodid	1.10	4.80	1.36
Sodium sulphate	None	None	None
Sod. metaborate	Trace	None	Trace
Sodium nitrate	Trace	Trace	Trace
Sodium nitrite	Trace	Trace	Trace
Sodium bicarb.	2,213.78	424.71	1,331.15
Calcium bicarb.	1,829.14	3,380.84	2,519.74
Barium bicarb.	16.67	25.65	25.00
Strontium bicarb.	Trace	Trace	Trace
Ferrous bicarb.	9.94	40.07	5.86
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Look for the Seal of The State of New York on every bottle of the genuine waters of Saratoga Spa.



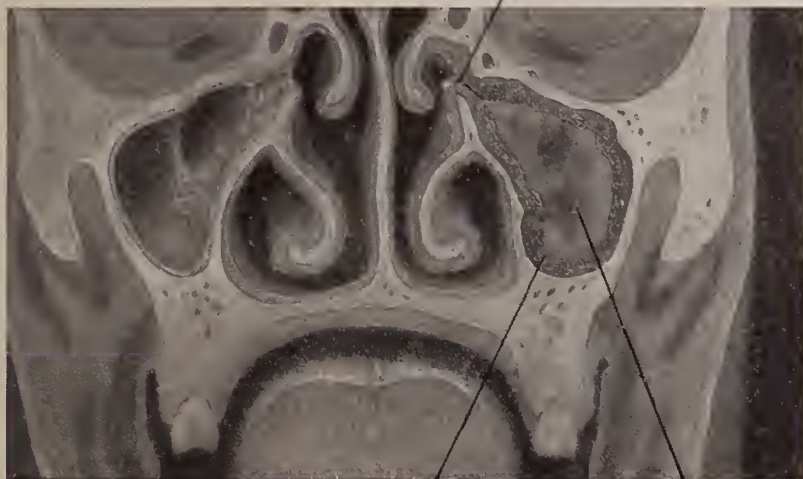
THE BOTTLED WATERS OF SARATOGA SPA

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PATHOLOGY OF THE UPPER RESPIRATORY TRACT: 2

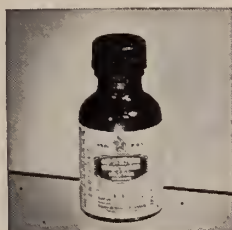
Closed ostium of antrum



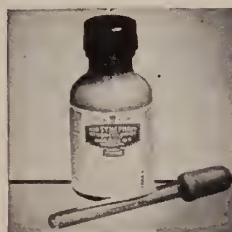
Congested mucous membrane

Antrum filled with pus and mucus

INFECTION OF THE ANTRUM OF HIGHMORE



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EMULSION



JELLY

CARDINAL principle of treatment of such infections is establishment of free drainage. To do this without surgery the mucous membranes must be shrunk thoroughly—for long periods, yet without local toxic effects.

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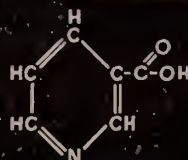
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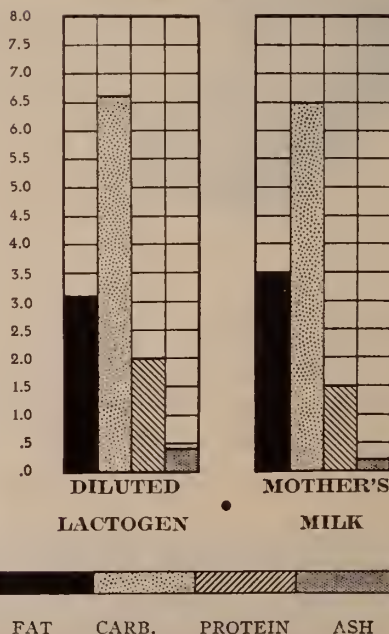
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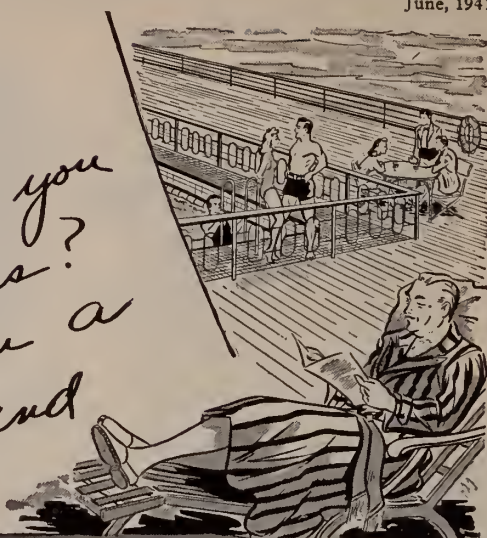


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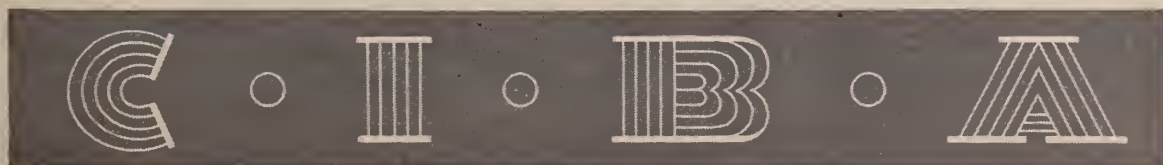
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EDITORIAL

MEET TOM LEWIS

New Jersey's Number One medical man this year is Thomas K. Lewis, M.D., of Camden, who last month became the 157th President of The Medical Society of New Jersey. Dr. Lewis was born in Merchantville in 1887, and was graduated from Haverford in 1909 after a career in which he won top-notch distinction for both athletic and scholastic activities. He was graduated from the University of Pennsylvania Medical School in 1913 and after serving an internship in the Cooper Hospital in Camden, started to engage in the private practice of medicine when he was called to active duty and served for 18 months overseas with the Medical Corps of the U. S. Army. He was Commanding Officer of the 165th Ambulance Corps of the Rainbow Division.

Since returning from the Army Dr. Lewis has been engaged in practice in Camden and has been active in civic, fraternal and medical affairs in the South Jersey metropolis. At one time he was President of the Lions Club in Camden, and has been President of both the Camden City Medical Society and the Camden

County Medical Society, as well as of the Physicians' Automobile Club. There is a general feeling in Camden County that whenever Dr. Lewis becomes active in an organization he is almost certain to wind up as president.

Dr. Lewis has two kinds of hobbies. One is a profound and solidly based interest in medical economics. At a time when most physicians were thinking only in terms of medical science and paying little attention to the social-economic facets, Dr. Lewis was quietly studying the economics of the distribution of medical care. As a result, when the need for intelligent evaluations of problems in economics became apparent, Camden County turned to Dr. Lewis.

In 1933, Dr. Lewis first attracted state-wide attention by an analysis of the problem of medical care for the indigent, which gave the rest of the state a chance to see what Camden County had known all along: that here was a man who really understood the problem in all its ramifications. From that time on his rise in organized medicine was swift.

Dr. Lewis's second hobby is athletics. He is an expert canoeist and likes to spend his vaca-

tions by taking his family on long canoe trips on the many small streams of our state. He has always been interested in playing golf, handball, football, soccer, and is probably one of the few doctors in the United States who knows how to play cricket.

With the Society facing a year that will surely be one of the most critical in its history, and with the need, as never before, for a calm and clear leadership, we consider ourselves fortunate in having a man of Dr. Lewis's ability and judgment at the head of our organization.

THE MORRIS ADMINISTRATION

"It happened in the Morris administration"—will be a frequently heard phrase for decades to come.

What happened in the Morris administration? The outstanding achievements of the 1940-41 year were the flowering of the Medical Service Administration and the high-g geared accomplishments of the Medical Preparedness Committee.

The Medical Service Administration, rooted in many years of study and preparation, finally reached reality in March, 1941, when the Commissioner of Banking and Insurance issued the Certificate of Authority. Under the leadership of Dr. Morris, the Plans of this Administration have been broadcast to a receptive public and have established in the mind of the community the willingness and ability of organized medicine to meet problems created by changing economic conditions.

The tremendous expansion of the Society's activities made necessary by the world crisis, suddenly placed upon Dr. Morris's shoulders the burden of certifying medical personnel for more than 200 draft boards, a dozen advisory boards and, at one time, as many as four induction stations. With the able assistance of a committee headed by Dr. Schlichter, Dr. Morris was able to supervise this tremendous job in record time, with an efficiency which won citations from high officials in both the Selective Service System and the War Department.

It was Dr. Morris's good fortune that the Society was plunged into these two history-making activities at the time when he was president; it was the Society's fortune that

when the need for inspired leadership arose, it had as effective an officer as Dr. Morris.

The Morris Administration will also be remembered as the period during which the Society most ambitiously undertook to meet one of its major functions—that of graduate education. Probably at no time in our history has there been more graduate educational activity than during the last year.

Particularly vigorous in 1940-41 was the work of the Public Relations Committee. Hundreds of newspaper items were published, giving favorable mention to the Society, and almost an entire page of one of the issues of the state's largest Sunday newspapers was given over to Society news on the occasion of the Lahey visit to Newark. The Speaker's Bureau had an especially active year, with a record of having filled, without exception, every assignment. And, as the Public Relations Committee stated in its annual report, "Dr. Morris was our Society's best good-will ambassador."

Finally, the Morris administration was ornamented by the celebration of the 175th Anniversary of our Society. Under Dr. Morris's warm and interested leadership, this birthday was celebrated by a series of inspiring activities, including special programs at the Annual Meeting, a lecture to the laity at which the President-Elect of the American Medical Association was principal speaker, and the presentation of a special historical brochure.

The eventful year just concluded, however, marks no blind alley in the history of the Society. Fortunately next year's program is in firm and fine hands.

THE SOCIETY LOSES DR. OVERTON

Having reached the age of three score and fourteen, Dr. Frank Overton, for seven and a half years Editor of this *Journal*, notified the Trustees last month that he would retire.

Dr. Overton's departure will leave a distinct void in the Executive Offices of the Society, where we had come to depend on him as an inexhaustible mine of information on medical history in general, and on the medical history of our State in particular. Dr. Overton was meticulous in his demand for absolute accuracy and exactitude, not only in the collection and verification of historical data, but also in the editing and preparation of this periodical.

Few medical journalists can claim as broad and rich a background as Dr. Overton. After a varied experience in private practice, he became interested in the public health field, and for many years won distinction as a District Health Officer for the State of New York. Always skilled in the technique of making medical information interesting, he responded to an early demand and wrote several text books on physiology and other basic sciences, which were standard in the public schools at the time. This rare combination of public administrative skill and journalistic ability brought him to the attention of the New York State Medical Society and led to his appointment as Editor of its *Journal*. In February, 1934, The Medical Society of New Jersey was able to lift him from New York and place in his hands the conduct of our own *Journal*.

From the day he assumed editorship, the one interest in his life was this *Journal*. He gave

to it 100 per cent of his working time and working thoughts. He was intensely jealous of the reputation of The *Journal*, and conducted the periodical with the same proficiency that had won acclaim in public health work, and with the same preciseness that characterized all his other activities.

It is with real regret that we see him leave us; a regret tempered only by the fact that few men have worked harder and earned their rest more deservedly than Frank Overton.

At the May 22 meeting, the Board of Trustees adopted the following resolution:

Whereas, Dr. Frank Overton, for many years associated with The Medical Society of New Jersey as Editor of the *Journal*, is as of May 31, 1941, retiring from that office; and

Whereas, he has rendered many services to The Medical Society of New Jersey as Editor and as a good-will emissary of the Society; and

Whereas, his efforts have been untiring in gathering historical data of value and interest to The Medical Society of New Jersey; and

Whereas, his work has been invaluable in creating an Index of the Transactions of the House of Delegates and Board of Trustees; therefore

Be it resolved, that this Board of Trustees of The Medical Society of New Jersey expresses to Dr. Frank Overton its deepest appreciation for the work so cheerfully performed and extend to him their best wishes and good cheer for the future, and

Further be it resolved, that this resolution be included in the annual report of the Board of Trustees.

The Publication Committee heartily endorses this resolution.

HENRY C. BARKHORN, M.D.,
Chairman, Publication Committee.

WHOSE AMERICA IS THIS?

Following a demand during the meeting of the Selective Service group, that the government give an iron-clad guarantee against malpractice suits arising out of draft board duties, Dr. Eagleton made the following remarks:

"I am shocked at any such suggestion. You do not know what you are doing. I resent the medical profession's giving voice to any such sentiment. We have been assured of proper government protection. What more do we want? Whose government is this? Who grants you your license, who protects you in practice? The government! Do we need our own government to give us further

assurances against a hypothetical condition before we do our duty?

"This defeatism, this materialism, this Lindberghism, is the most sinister and dangerous movement in our nation today. You ask assurance from Uncle Sam. Who is Uncle Sam? I am 1/130 millionth part of Uncle Sam and I ask no particular protection for performing my duty. Because a man has been sued, need we ask for more assurance of protection than has been given us tonight? As one of the senior members of this Society, I hope that Dr. Rowntree will obliterate from his mind any thought that any appreciable number of New Jersey physicians want more assurance than has already been given, before performing their duties."

DR. DANZIS RECEIVES E. J. ILL AWARD

Dr. Max Danzis, Newark surgeon, received the E. J. Ill Award of the Academy of Medicine of Northern New Jersey, for 1941. Following is the citation address, made at the Academy on May 15, by Dr. Charles M. Robbins, retiring President of the Academy:

Deep, indeed, must be the gratification that comes to a man, when after a lifetime of conscientious work, he senses that his efforts have ripened into accomplishment. But a deeper and warmer glow must stir him when, upon an occasion such as this, surrounded by his own colleagues, comes the crowning reward of all—the concrete manifestation by them of their affection and their recognition of his notable attainments.



Left to right: Drs. Edward W. Sprague, Max Danzis, Charles M. Robbins, Wells P. Eagleton.

Today, Dr. Danzis, it is the honor of the Academy to bestow upon you the highest reward within the gift of our organization—denoting thereby that your life-work has been an unquestioned success.

It would be idle, at a time like this, to speak in detail of your achievements, or to make reference to your scholarly papers, or to the significant studies you have made in many phases of medicine and surgery. It is more pertinent in these days of turmoil, to say something of your struggle from most humble beginnings.

Your story takes on a truly epic quality. The account of your life accentuates the glory that is the American way of life. Yours is the tale of the immigrant boy, emerging from the darkness of Czaristic Russia. One of twelve children in a Jewish home in a small provincial village—without scholastic opportunity, without means, and without hope. In 1890, a lad of sixteen, you dared the road of the pioneer. Without family or friends, but with a passionate desire for learning, for freedom, and

for service, you came to this great country to carve out a career.

In the teeming slums of New York's East Side you commenced to study, occupied in menial tasks by day, and in acquiring knowledge by night. Six years of ardent study—and you, the penniless untutored boy, were ready for admission to the Bellevue Medical School. Three years later you were a physician.

You have built a career of service. For over two score years you have been a diligent friend, guide and physician to thousands of men, women and children of every race, creed and color. You have never been found wanting, when there came to you the call of the poor, the needy and the distressed.

There are young men in the profession who today rejoice because a great honor is being bestowed upon you. For to them, and in their lives, you have been an ennobling influence. It is with unalloyed pleasure that I number myself among them. On this occasion that will always be memorable to me as well as to you, I speak with humility, and with a heart full of gratitude for my personal indebtedness to you, for the paternal counsel, and for the warm friendship with which you have always blessed me.

For more than three decades your major work related to the establishment and maintenance of the Beth Israel Hospital. Today this great structure stands as a symbol of your vision. You have been its President and its leading spirit. And it is evidence of your stature in the profession, that in the course of the years you have been President of the Essex County Medical Society, President of the New Jersey Society of Surgeons, President of the Academy of Medicine, a Trustee of the Newark University, and a leader in Jewish and communal affairs.

The ancient Psalmist, in simple but eloquent words, has said:

"When thou shalt eat the labor of thine hands, happy shalt thou be, and it shall be well with thee."

How devoutly you have heeded this precept! You have thrived by the labor of your hands. You have built your own edifice of service. This has become a structure of enduring character, of lofty architecture, and of limitless utility. Your life has become not only a monument to your labors, but also a source of beneficence to all of us.

It is such a career, and such a personality, that has distinguished you among your fellows as the man worthy of the highest honor of our Academy, The Dr. Edward J. Ill Award "for extraordinary service as a physician and as a citizen."

To Max Danzis

Inspiring Executive
Gifted Surgeon
Forceful Citizen.

ORIGINAL ARTICLES

HYPERINSULINISM

By LEONARD G. ROWNTREE, M.D., Philadelphia, Pa.

Philadelphia Institute for Medical Research, Philadelphia General Hospital

Acknowledgment is made with gratitude for financial support from the Doland Fund of the American Physiological Society. Read before the Section on Medicine of The Medical Society of New Jersey, 174th Annual Meeting, Atlantic City, June 6, 1940.

Hyperinsulinism is a term used to designate a chronic disease characterized by intermittent hypoglycaemic attacks due to an excess of insulin, accompanied by gradual physical, mental and physis changes affecting the personality. Hyperinsulinism is also frequently designated "spontaneous hypoglycaemia".

My interest in this disease dates back to 1927 when many of us at the Mayo Clinic were intrigued and puzzled by the clinical problems presented by the patient whose case was later reported by Wilder, Allan, Powers, and Robertson,—the first case in which an anatomical basis was revealed for the clinical syndrome concerned. The history of the disease is worthy of note. Insulin was discovered by Banting and Best in 1922, and the symptoms of insulin shock or hypoglycaemia were immediately recognized and described by the Toronto group.

Two years later, in 1924, Seale Harris published three case reports of patients presenting a peculiar syndrome, characterized by intermittent attacks of spontaneous hypoglycaemia, which he regarded as due to an *excess of insulin*. In a series of articles he developed the idea that there exists a disease the opposite of diabetes mellitus, which results from an excess of insulin (hyperinsulinism), instead of a lack of insulin (hypoinsulinism) as encountered in diabetes.

Then appeared the enlightening report of Wilder and his colleagues at the Mayo Clinic. The patient, a surgeon, developed, on fasting, hunger and weak spells which could be warded off or corrected by food. This became progressively more marked so that the doctor's wife was obliged to slip candy into his mouth in the early morning hours so as to prevent collapse. The patient himself recognized the nature of his disease, and discovered in frequent feedings, or the taking of sugar, a pallia-

tive form of treatment. At operation a tumor of the pancreas was discovered by Dr. W. J. Mayo, and also a large metastatic tumor in the liver. The patient succumbed a month later. The tumor and the metastatic tumor were composed of islet cells. An anatomic basis for the disease was thereby furnished, but in addition it was demonstrated that the metastatic tumor cells were capable of elaborating relatively large amounts of insulin; and also that under these conditions the insulin was furnished to the organism in an abnormal way and in excessive amounts. They also demonstrated that glycogen in this disease was firmly bound in the tissues.

Next in order, Finney and Finney explored a patient with a somewhat similar clinical picture, found no tumor, and so resected part of the pancreas, with but meager results. In 1930 Graham and Howland, and their collaborators, resected tumors and brought about cure. Thus in the short space of one decade insulin was discovered, insulin shock defined, a new disease described, and cure effected in cases due to tumors arising in the cells of the islands of Langerhans.

As time passed it was learned that attacks of spontaneous hypoglycaemia are of common occurrence, but that tumors of the islands are relatively rare. In fact, tumors of the pancreas of the islet-cell type are exceedingly rare, probably less than 100 being encountered to date. Malamud and Grosh include 27 cases in their collective review in 1938, out of 99 patients diagnosed as suffering from hyperinsulinism. Spontaneous hypoglycaemia, on the other hand, is extremely common, especially in its mildest form. Low blood sugar probably plays an important rôle in the pathogenesis of weakness and exhaustion in many patients suffering from all kinds of debilitating functional and organic

diseases. Even where the diagnosis of hyperinsulinism is definitely established, tumors will be found in only a small percentage of the cases.

Some have attempted to limit the term *hyperinsulinism* to cases with an organic pathological basis in the pancreas; while others, the majority, use the term in its broader sense to cover all cases of spontaneous hypoglycaemia irrespective of whether the increased secretion of insulin is due to organic or functional factors.

SIGNS AND SYMPTOMS OF HYPOGLYCAEMIA

The symptoms and signs of the disease may be extremely protean in character and yet they adhere to a certain pattern which renders recognition easy as a rule, provided the physician is insulin-minded. The hypoglycaemic attacks are likely to occur after prolonged fasting, i. e., in the early morning hours or before meals. They are made worse by continued fasting or by exercise, and are relieved promptly by the ingestion of food, especially of carbohydrates in the form of sugar, candy, fruit juices, etc. They are characterized in mild forms by the sensation of hunger, feeling of weakness or faintness, light-headedness, anxiety, by pallor, sweating and trembling; and in more severe attacks by the same clinical features, and in addition prostration, mental lapses, period of unconsciousness, muscle spasms, shivering, chattering of the teeth, and spells resembling petit mal.

In the most severe forms occur hysteria, unconsciousness, coma, convulsions, the attacks resembling in many ways the grand mal seizures of epilepsy. Actual psychoses may develop. Abdominal pains, cramp-like in character, are not unusual, and have led to surgical intervention at times. The abdominal pain, however, like the other symptoms, yields readily to food.

The personality changes may be extreme, yet, because of their gradual development, they are rarely accorded the consideration which is their due, because of the centering of attention on the more dramatic hypoglycaemic episodes. Many of the patients lose ambition, become nervous, excitable, irritable, and irresponsible, frequently dropping lower and lower in the

social scale. Many of them are to be found wandering from one clinic to another, incarcerated in jails, or lodged in the wards of general hospitals, or in psychopathic, State, or penal institutions.

The signs and symptoms may be so numerous and varied, the patient's behavior so strange and bizzare that the physician may find himself following will-of-the-wisps, diagnostically and therapeutically, until the nature of the disease is recognized. The nervous system particularly bears the brunt of damage, as evidenced by innumerable signs and symptoms of involvement of the brain, and the central and the autonomic vegetative nervous systems. Patients with this disease may run the gamut of nervous manifestations and be considered erroneously at first as the victims of some functional or organic disease. The symptoms vary from hunger, weakness, light-headedness, and feeling of fullness in the head, to mild headache, confusion, uncertainty, dizziness, vertigo, disorientation, and spells resembling petit or grand mal. Narcolepsy, amnesia, delirium, convulsions and coma may develop. The diagnosis may range from neurasthenia, hysteria, alcoholism, epilepsy, psychosis, to encephalitis and tumor of the brain. Innumerable forms of therapy may fail until the hypoglycaemia is discovered and the blood sugar level restored to normal, whereupon all symptoms and signs may disappear and the patient promptly return to his normal self. From this it would appear that an excess of insulin may be as harmful to the brain of a normal individual as it is helpful to the brain of patients suffering from dementia praecox.

LABORATORY FINDINGS

The only laboratory finding constantly of crucial significance is a low fasting blood sugar. In a general way, it may be said that the lower this falls the more severe the symptoms. Values below 50 mg. per 100 cc. of blood usually are accompanied by serious clinical manifestations, and suggest the presence of organic pathology in the pancreas.

Many physicians attach considerable significance to glucose tolerance curves, more especially to flat curves at low levels ending in

marked depression. Wilder, however, has found that almost any type of blood sugar curve can be encountered in tumors of the islets.

The time element is said to be important by some authorities. Thus Harris prefers a six-hour glucose tolerance test, with special emphasis on the figures for the fifth and sixth hours. Wilder advocates a 30-hour fast before making a blood sugar test, if hypoglycaemia does not appear earlier. Woodyatt advises keeping ambulatory cases up and about at the time of tests. Repeated tests are desirable since great variations may be encountered in these findings if taken at different times.

DIAGNOSIS

This rests on the clinical history, the presence of the cardinal symptoms and signs of hypoglycaemia, and on the laboratory findings of low levels of fasting blood sugar. It then becomes necessary to ascertain whether the attacks are spontaneous or induced in character. The latter should be suspected obviously in all diabetic or other patients to whom insulin is being administered.

Because the disease is readily eradicated when tumors of the islet cells are removed surgically, differential diagnosis assumes large proportions. In this connection it is necessary to consider the various organs concerned in sugar metabolism, and the various mechanisms that may be involved. These include the pancreas, organically and functionally; the glycogen storage depots of the body, especially the liver and muscles; other glands of internal secretion concerned in carbohydrate metabolism, particularly the pituitary and adrenal glands; the brain and nervous system; and the sugar supply and its abnormal loss from the body as encountered in diabetes and in lactation.

DIAGNOSIS

The diagnosis of an islet-cell tumor is arrived at mostly by exclusion. When organic disease involving sugar depots, other endocrine glands, nervous system, etc., are excluded, attention must be centered on the pancreas itself. Extremely marked hypoglycaemia with fasting

sugar repeatedly below 50 mg. per cent is suggestive. Likewise prolonged persistence of the disease in the continued absence of clinical evidence involving other organs makes organic involvement of the pancreas more likely. Exploration may be necessary for establishing the diagnosis, but in some instances even this may fail. Thus it has been found that small tumors have escaped detection on first exploration and have been encountered and removed at subsequent operation. It must be remembered that even a small islet-cell tumor a half centimeter in diameter may cause the disease; and that such tumors may exist and escape both the searching eye and palpating finger of even a first-class surgeon. Failure to find a tumor does not always preclude its presence. Other diseases must be differentiated from organic pancreatic disease by their clinical history, physical findings and laboratory studies.

But even in the presence of another disease capable of inducing hypoglycaemia it is not always easy to decide that this associated disease is responsible for the clinical picture. Such a situation faces me now in one of my cases of Addison's disease.

CASE REPORT

The patient is a young man who has suffered for five years from both Addison's and Buerger's disease, who is now undergoing hypoglycaemic attacks with changes in behavior and personality. Having survived and having been markedly rehabilitated throughout the last five years, on Swingle's extract of the adrenal cortex, and a high salt intake, he has lately assumed that except for pigmentation he has fully recovered. As a result he has resisted further treatment and neglected his medication, and hypoglycaemic spells have developed. These were unaffected by desoxycorticosterone, but have responded to some extent to the cortical extract of the suprarenal prepared by Professor Swingle.

The patient's clinical manifestations are indistinguishable from hyperinsulinism. Are they of pancreatic or of adrenal origin? If Addisonian in character, it is the first time in my experience, in a series of approximately 150 cases of adrenal insufficiency, that I have seen such a picture. In differential diagnosis functional and organic nervous diseases must be excluded, especially chronic nervous exhaustion, psychoses, epilepsy, encephalitis, and brain tumor. Other diseases demanding frequent consideration are ulcer of the stomach and duodenum, cirrhosis of the liver, and adrenal insufficiency.

In arriving at the diagnosis the greatest importance attaches to, 1, the occurrence of symptoms during fasting; 2, their prompt disappearance following the ingestion of sugar; 3, the low level of fasting blood sugar; 4, the time coincidence of symptoms with hypoglycaemia; and 5, the exclusion of other factors capable of inducing such symptoms.

PROGNOSIS

The prognosis in spontaneous hypoglycaemia is poor as a rule. The disease is progressive. If it is the result of islet-cell tumor, complete recovery may follow its removal, but the operative risk and surgical mortality are high. Only six of twelve Mayo Clinic cases survived removal of the tumor, and tumors were found in less than 50 per cent of the cases they explored.

In other forms of spontaneous hypoglycaemia recovery is unlikely because, 1, the disease is usually progressive in character; 2, medical treatment and dietary management are unsatisfactory except as to palliation of symptoms; and 3, other diseases capable of causing non-insulinogenic hypoglycaemia must be of advanced nature as a rule before inducing the attacks, and therefore are dangerous per se.

TREATMENT

Treatment should be considered under several headings: 1, Management of the hypoglycaemic spells; 2, dietary regimes; 3, medicinal therapy; 4, surgery; and 5, other considerations. While the results of symptomatic treatment of the individual attacks and the surgical removal of tumors are excellent, treatment on the whole is very unsatisfactory.

1. MANAGEMENT OF THE HYPOGLYCAEMIC SPELLS

Relief of the hypoglycaemic attacks may usually be obtained promptly and effectively by the administration of food in the milder cases, and of glucose intravenously in more severe cases. Orange juice, fruit juices in general, milk, in fact food in almost any form, but especially food rich in carbohydrates, sugars, candy, chocolate, are all strikingly effective. Perhaps nothing in medicine is more striking

and dramatic than the prompt return to normal, of a patient in a coma or convulsions following the intravenous administration of small amounts of glucose. In mild cases a glass of orange juice may induce a miracle. Thus we have repeatedly demonstrated the prompt restoration to normal of completely demented patients suffering from hypoglycaemic shock, in the course of five to ten minutes following appropriate treatment. However, excessive carbohydrates must be avoided since they act to stimulate insulin production, and hence carry the danger of inducing secondary attacks of hyperinsulinism.

2. DIETARY MANAGEMENT

Dietary management is helpful to some degree, but in the long run it is rather disappointing. Frequent feedings are best,—six or even eight small meals scattered through the course of 24 hours, instead of three large meals. This becomes more or less imperative in advanced cases. Naturally the daily caloric needs should be considered and excessive intake avoided. The diet which seems to have met with most approval is that of low carbohydrate, high fat, and moderate protein, based on the amount of each per kilogram of body weight, as follows:

Carbohydrate per kilogram of body weight	1.25 to 2 grams
Protein	1 gram
Fat	2 to 2.25 grams

Some prefer a diet richer in proteins. Symptoms and blood sugar determinations will yield valuable criteria in guiding treatment.

MEDICINAL THERAPY

Drugs have proved of but little help. Small doses of insulin one-half hour after meals low in carbohydrates have been advocated by Johns. Belladonna and phenobarbital have been tried, but found wanting. Thyroid in large doses may be helpful in some cases. Pituitary products may eventually be found helpful, especially the diabetogenic hormone of the anterior lobe. Desoxycorticosterone is of little or no benefit since it is lacking in its effect on carbohydrate metabolism. The cortical hormone of the adrenal glands may be tried. We have found it somewhat helpful in one instance.

SURGICAL INTERVENTION

In this connection certain facts should always be kept in mind:

1. Removal of an islet-cell tumor will probably result in cure; while a subtotal pancreatectomy may prove of distinct benefit.

2. The surgical mortality is high.

3. The disease is usually progressive, and medical management inadequate.

4. Our knowledge of this disease is in the making; and hence exploration may not only reveal a curable lesion, but also it may help in giving a clearer insight in the management of hyperinsulinism.

5. Failure to find a tumor does not preclude its existence.

Tumors when found should be removed. More than one tumor is often present, hence multiple tumors should always be sought. As soon as a tumor is located, small amounts of insulin should be administered to prevent subsequent hyperglycaemia which often results within a few hours from the removal of an islet-cell tumor.

In the absence of tumors, contributory pathology should be sought, i. e., gall-stones, duodenal ulcers, pancreatitis, pathology of adrenal gland, and liver. If found, they should be accorded appropriate treatment.

In the absence of obvious pathology, subtotal resection of the pancreas may be attempted by

the procedure advocated by Thomasen, Berry, or Graham. A strong ligation may be applied around the pancreas near the head, and the pancreas sectioned peripherally to this with a Percy cautery. If pancreatectomy is attempted, it should be extensive rather than limited in character. If healing is slow, recovery retarded, and fistula develops, the need of insulin administration should be kept in mind.

OTHER FORMS OF MANAGEMENT

Rest, warmth, peace of mind, and freedom from physical and mental strain, are all employed. Special attention to the psychic side is always desirable.

Appropriate therapy for concomitant diseases must be sought and administered.

In deciding as to whether medical or surgical treatment should be employed, the following considerations are significant:

1. The disease is usually progressive.

2. Tumors, if present, may metastasize.

3. Obesity and personality changes, and more marked invalidism are apt to develop under medical management.

4. Only surgery is likely to bring cure.

Chronologically this is a new disease, and medical knowledge is in the making. Since it is serious if unchecked, exploration and rational attempts at radical therapy are justifiable to a certain extent, even though unsuccessful. Better methods of treatment are urgently needed.

CARDIOVASCULAR DISTURBANCES IN GASTROINTESTINAL DISEASES

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Read before the Combined Sections of Medicine and Gastro-enterology of the Annual Meeting of The Medical Society of New Jersey in Atlantic City on June 4, 1940.

The thought that some possible relationship exists between cardiovascular disturbances and gastrointestinal diseases is quite old. The so-called "heart burn" associated with palpitation of the heart, which was usually relieved by bicarbonate of soda, and the practice of food fasting at stated intervals to lessen the discomfort of a throbbing or annoying heart, are

two well-known examples of treatment which are mentioned in the writings of the past and which have done much to keep alive the thought that in some manner the stomach and heart are under the same functional influences.

During recent years, however, due to experimental physiology and more careful study of pathological anatomy, the true significance of

gastrointestinal disorders and cardiovascular upsets are becoming more appreciated. In spite of all that is known concerning this inter-relationship, however, much confusion still exists, both in the minds of the medical profession and in that of the general public. Stomach disorders are still diagnosed as heart disease; and heart disturbances are constantly ascribed to attacks of acute indigestion.

Some of this confusion is quite justifiable. Even physicians who have had wide diagnostic experience encounter great difficulty in separating the two.

The stomach is a very unusual organ. It is so easily upset that it has been termed "the alarm clock of the body". In many instances it is out of order when the stomach itself is not at fault. One only has to recall the vomiting of pregnancy, and the belching of gas in gall-bladder diseases, to realize that such a statement is true. In neither instance is an abnormal stomach the real seat of the disturbance.

The great importance of looking beyond the organ which appears to be the most upset cannot be too strongly emphasized. Do not close your mind until your investigation is complete. Try to make the disease fit your findings, rather than make the findings fit the disease.

As the tempo of life has increased, the pertinence of these facts become more apparent. The question arises, then, whether there is a difference between the symptomatology of cardiovascular disturbances and gastrointestinal diseases, or whether the confusion is the result of inadequate care and study. The similarity is more apparent than real. A careful diagnostic approach will usually separate the two. It is with the hope that more care will be exercised in the future that this paper is presented.

There are anatomical and physiological reasons why the functions of the cardiovascular system and the digestive apparatus should be interrelated. They are both supplied by the vagus and the sympathetic nerves, and what stimulates or disturbs one should influence the other. Cardiac efficiency is dependent upon proper vagal and sympathetic nerve balance. Cardiac inhibition can be induced by overstimulation of the vagus nerves. Isn't it proper,

then, to surmise that two systems which have the same nerve supply might be influenced or disturbed in a similar manner? That, apparently, is what takes place.

Although the vagus nerves arise in the medulla of the brain, they pass through the chest into the abdomen and terminate by forming the nerve plexus of the lesser curvature of the stomach. As the vagus nerves pass through the chest, branches are given off which join the sympathetic nerves to form the esophageal plexus, the cardiac plexus, and the coeliac plexus. From the coeliac plexus, vagal rootlets pass on to the gall-bladder. Hence, the vagus nerves supply the mucous membrane of the esophagus, the stomach, and the gall-bladder. Not only do these nerves supply the esophagus, the heart, the stomach and the gall-bladder, but each plexus entwines itself about the vital parts of these organs, and undoubtedly exerts great influence upon their function.

1. The esophageal plexus engulfs the lower esophagus.
2. The gastric plexus accompanies the gastric blood supply.
3. The coronary plexuses accompany the right and left coronary arteries.
4. The vagus rootlets ramifies the wall of the gall-bladder.

Any enlargement or anatomical changes in these organs most likely exert pressure, or disturb these vagal rootlets in some manner.

The second suggestion that there must be some interrelationship between these two great systems comes from the fact that their symptomatology is very difficult to differentiate. Gradually, however, clinicians are taking a more positive stand, and offer data to prove that gall-bladder disease, gastric ulcers, and disturbances of the lower end of the esophagus really influence the actions of the heart.

As early as 1878, some French observers noted the close relationship between gall-bladder disturbances and heart disease. The late Sir William Osler also said, "If a patient complains of his heart, think of his stomach; if he complains of his stomach, think of his heart."

Dr. Herbert Breyfogle, of Kansas City, Mo., brought the subject up to date in an article,

"Coexisting Gall-bladder and Coronary Disease", in the J. A. M. A., April 13, 1940. In a series of 1,493 cases, he found 162, or ten per cent, in whom gall-bladder disturbances and coronary disease coexisted. He asks whether chronic gall-bladder disease predisposes to coronary disease; or whether a decrease in myocardial efficiency, due to coronary disease, predisposes to gall-bladder disturbances? This author favors the former conclusion.

Drs. L. M. Morrison and W. A. Swalm, of Philadelphia, in the J. A. M. A., January 20, 1940,—"*Rôle of Gastrointestinal Tract in Producing Cardiac Symptoms*",—attempted to prove that distension of the lower end of esophagus with a rubber bag would produce attacks of angina. Real anginal attacks which were confirmed both clinically and by simultaneous electrocardiogram tracings were presented.

G. Von Bergman in the Deutsch Med. Wchnschr April 15, 1932, showed that inflation of a balloon in the stomach of a dog would produce coronary vasoconstriction which could be abolished by atropine. Do these data prove that every dilated esophagus and stomach causes angina? Some may and many do not. Some are unquestionably more susceptible than others, due to factors which are yet unsolved.

As the span of life has increased from an age expectancy at birth of 42 years, to more than 60 years of today, a very large group of both sexes have arrived at an age when both cardiovascular and chronic gall-bladder diseases, due to arteriosclerosis changes, are more apt to occur than formerly.

Aside from this advanced age group, however, in whom one must expect almost any disease to which the human body falls heir, there are some who are unquestionably ushered in at an earlier age than are recognized. It is from this more or less premature age group that I wish to present some cases.

CASE NO. 1

J. B., male surgeon, aged 55, who was first seen about 15 years ago.

Chief Complaint: Sudden retrosternal pain.

Family History: Irrelevant.

Past History: He had the usual diseases of childhood but was always well.

About 15 years ago while operating, he was seized with a profound retrosternal pain and fell to the floor in shock. A feeble pulse, fever, leucocytosis, fall in blood pressure, rapid sedimentation rate and changes in the electrocardiogram confirmed *anterior coronary occlusion*. After eight weeks in bed, he recovered. After a year he returned to his operative duties, but felt uncertain and nervous.

From time to time he had a return of precordial pain, and feared that he had a second coronary occlusion; but all tests were negative. This status prevailed for about nine years, when he was seized again with a very severe pain in his chest which did not subside in spite of treatment. Further study revealed a chronic non-functioning gall-bladder filled with stones. He was finally operated upon and a badly diseased gall-bladder was removed. Since that time he has been most active as a surgeon, yet entirely free from any of his former disturbance.

CASE NO. 2

Mrs. J. G., housewife, aged 74, who was first seen about ten years ago.

Chief Complaint: Recurring choking pains in chest which began in pit of stomach and went up into the neck.

Family History: Mother and father lived to matured age.

Past History: Always quite well, except for "bilious attacks" for many years.

Present Illness: Really began 15 years ago following the loss of her husband. She vomited quantities of bile, and the condition was diagnosed gall-bladder disease. Following this spell she had to be careful about her diet. Several years later she was taken with the same retrosternal pain which radiated from the side of her neck to her left arm, and necessitated large doses of morphine to control it. Tests and electrocardiograms confirmed an anterior coronary lesion. After seven weeks in bed, she completely recovered.

During the past eight years she has had recurring attacks of similar precordial pain which require one-half grain morphine. These attacks have continued to recur at closer intervals until now she has one about every month. They are still very severe and defy both her home physician and myself to differentiate them from typical coronary occlusions. At no time, however, were there any laboratory findings or electrocardiogram changes to confirm it. In about 24 to 48 hours she is comfortable again, and can get out of bed. She refuses operation, and has to be treated medically.

CASE NO. 3

C. P., male manufacturer, aged 56, who was first seen about four years ago.

Chief Complaint: A history of severe retrosternal pain preceded by indigestion.

Family History: He did not remember much about his parents.

Past History: He had always been well and worked very hard. Following the depression he incurred great losses, and was under a great physical and mental strain. One night, following a large din-

ner, he was seized with a severe pain in his chest, followed by nausea and vomiting. He finally got relief, but never felt quite like he had formerly.

He consulted several physicians who told him that he was quite all right, and that his heart was fine. Finally, a complete gastrointestinal study was made and from that time on he was treated for indigestion. Several months later he consulted another doctor, because of great pains in his legs following walking, and he was treated for rheumatism. Finally he came to the seashore to live.

Present Illness: His present illness really was a continuation of his last attack of pain, but he still commuted to New York once a week. Finally he called me in to see him because he had indigestion regardless of what he ate. When I saw him, in spite of physical findings, a history of indigestion and shortness of breath following eating made me feel that the condition was cardiac, and not gastric.

Following a large meal, he was again seized with a pain in his lower chest, accompanied by shock, vomiting, fever, increase in sedimentation rate, and electrocardiogram evidence of anterior coronary occlusion.

After twelve weeks in bed he got up and about. Several months later he ate a large meal again, and was taken with nausea and shortness of breath, but could not vomit.

When I saw him he was in shock, had great pain in the pit of his stomach, and his blood pressure had fallen from 125 to 90, and my conclusion was that he had another occlusion. He refused all tests and went to the bathroom against my advice only to pass away upon his return to his bed.

SUMMARY AND CONCLUSIONS

1. Much confusion still exists in differentiating between cardiovascular disturbances and gastrointestinal disease. Many patients are treated for stomach trouble when careful study would show that the heart and circulation are at fault.

2. There is much evidence to prove that chronic gall-bladder disease, chronic gastric ulcers, and disturbances of the esophagus, predispose to coronary disease because they are all under the control of the same nerve supply.

3. In spite of the great similarity between the symptomatology of the two systems, careful study will usually separate gastrointestinal disturbances from cardiac diseases.

4. The case reports of Breyfogle, Morrison, Swalm, and Von Bergman suggest that dilatation of the esophagus, the stomach and gall-bladder cause vasoconstriction of the coronary arteries. Vasoconstriction of the coronary arteries cause myocardial ischemia. Ischemia is a lack of heart muscle blood supply which results in myocardial inefficiency. Hence, there is much to prove that gastrointestinal diseases do induce cardiac disturbances.

OCURRENCE AND TREATMENT OF SPONTANEOUS TRAUMATIC PNEUMOTHORAX IN BILATERAL ARTIFICIAL PNEUMOTHORAX *

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Spontaneous bilateral pneumothorax is a real emergency that is little understood. Its consequences may be tragic unless treatment is swift and effective. The purpose of this report is to present a successful form of therapy. A brief preliminary review of the nature of spontaneous pneumothorax seems necessary for an understanding of this treatment.

The word pneumothorax means air in the chest cavity. Artificial pneumothorax is the induction of air into the pleural cavity by artificial means. Spontaneous pneumothorax is a leak or an influx of air into the pleural cavity

due to rupture or some other pathology of the pleura.

Etiology: Any process which destroys parts of the lung tissue is a potential cause of spontaneous pneumothorax. Abscesses, gangrene, tumors of the lung—all have caused the disorder. The most common cause is tuberculosis.

Incidence: Few figures are available from which the incidence of spontaneous pneumothorax can be computed. Perhaps the most careful analysis is that made by Dorendorf,¹

* This work is the outcome of experimental studies conducted in the Chest Department of the Newark Beth Israel Hospital and the Tuberculosis Service of the Newark City Hospital.

who calculates that six per cent of all patients with tuberculosis of the lung have had spontaneous pneumothorax at some time or other.

Types: The air escapes from the lung into the pleural cavity through a spontaneously produced pleuro-pulmonary fistula. When this channel is sealed, the disorder is identified as a *closed* type of pneumothorax. On the other hand, when free communication between pleural cavity and the lung fistula is maintained, the pneumothorax is of the *open* type. Finally, in some cases a fibrinous flap in the opening will permit air to enter the pleural space on inspiration, but may block the return of air on expiration. This is the so-called *valvular* type.

Identification: Manometric readings of pleural pressure identify the types. In the valvular type an increased positive pressure is noted; while in the open type, manometric reading remains at zero. In closed pneumothorax, the manometer shows a fall in pressure during inspiration.

Symptoms: Onset of spontaneous pneumothorax is subjectively signalled by sharp chest pain, dyspnea, cold sweats, and very rapid breathing.

Signs: The patient appears cyanotic. The affected side of the chest seems somewhat expanded. Percussion shows that the heart has been displaced away from the pneumothoracic side. Auscultation yields no breath sounds at all over the affected lung. Pulse is very rapid. The roentgenogram discloses a characteristically transparent lung field.

Prognosis: In unilateral cases, the outlook depends on the structure of the non-affected lung, the patient's general health, and the collapsibility of the lung on the pneumothoracic side. Dawson² finds a general mortality of 37 per cent. Symes-Thompson,³ on the other hand, says that the "patient usually recovers in the course of a few weeks, provided he has been in previously good health". Unfortunately, that is a big proviso. Most of the patients have certainly not been in good health. In any event, prognosis is grave in bilateral cases. If a patient with one lung already collapsed (by artificial pneumothorax) suddenly sustains spontaneous pneumothorax on the other side, he

can scarcely remain alive more than a few minutes without prompt intervention.

Treatment: General measures such as morphine, combatting shock, enforcing rest, etc., are usually, and often rather vaguely, recommended for unilateral spontaneous pneumothorax. Forced aspiration has generally been condemned. This disapproval is, I believe, without foundation. Indeed, speaking of his experience at the Middlesex Sanatorium at Waltham, Mass., Dawson² tells me that fifty forced aspirations have been performed without any death attributable to that procedure. And certainly for bilateral pneumothorax, heroic measures are emphatically indicated.

Our aim in the mechanical treatment of bilateral spontaneous pneumothorax is twofold:

First, we want to remove air from the pleural cavity, immediately relieving the deadly pressure on the heart and mediastinum.

Second, we want to encourage the pleuro-pulmonary fistula to heal by maintaining a negative pleural pressure. This means that we



FIGURE I.

must release excess air whenever it enters the pleural cavity.

Emergent Technique: Use a reversed "refill syringe". This is the kind of syringe equipped with a one-way valve designed to permit continuous injection of, or infiltration into, the tissues. In its ordinary use it is, in effect, a pump for maintaining a steady flow of fluid into the body. Figure 1 illustrates the refill syringe as used in its original function.

For prompt release of air or fluid in spontaneous pneumothorax, set up the refill syringe *in reverse*. The needle is attached to the end of the tubing that ordinarily dips into the medi-



FIGURE II.

cation, while the end of the apparatus to which the needle is attached in infiltration use is left free in the air. See Figure 3. As a result, the valve, originally constructed to maintain a flow *into* the tissue, now serves to permit flow *out* of the body and to check any return flow. See Figure 2. A shield is used for needle anchorage as well as for a base to which the adhesive strapping may be attached. (If no metal shield is available, a cork will do.) With this apparatus, air may be pumped out of the pleura by simply pushing the syringe piston in and out.

Non-emergent Technique: During the non-urgent or "chronic" phase, it is necessary to provide a mechanism, controllable by the patient, for the release of air. To effect this we have adapted a sphygmomanometer valve and set-screw. In the ordinary use of this appliance

for taking blood pressures, the valve allows air to flow into the cuff, but not out of it; and a turn of the screw closes or opens the tubing, releasing the air. By reversing the valve, the screw becomes a device for allowing air to flow out of the pleura, while a turn of the screw by the patient opens or closes the mechanism.

The successive steps necessary to adapt the sphygmomanometer valve and tubing are as follows: First consider the apparatus as set up for reading blood pressure. Call the side of

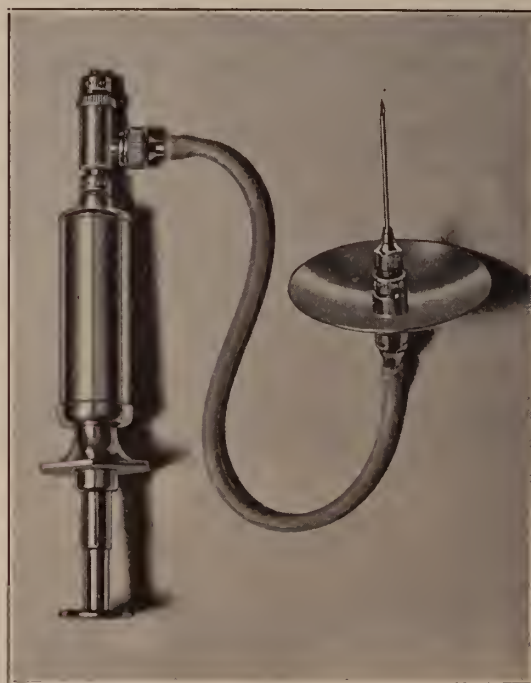


FIGURE III.

the screw towards the bulb the "bulb-side" of the screw; call the other side the "cuff-side". The tubing now runs from the cuff-side of the screw to the cuff itself. First step is to remove the cuff, second to remove the bulb. This leaves a metal teat at the bulb-side of the screw, the screw-valve itself, and the tubing at the cuff-side of the screw, in that order.

Now reverse the screw—that is, slip it out of the tubing, turn it around and re-insert it. Now, the metal teat faces to the cuff-side, while the tubing is attached to the bulb-side. Figure 4 illustrates this lay-out; with the addition of the metal shield. Next step is to place a needle, using an adapter if necessary, at the free end

of the rubber tubing. The mechanism is now arranged so that the needle is connected to the bulb-end of the screw, while the metal teat (now attached unaccustomedly to the cuff-end) is free in the air. If this needle is now inserted into the pleural cavity (Figure 5), the patient can permit air to escape simply by turning the screw counter-clockwise. No air can be sucked into the pleura, however, because of the check-



FIGURE IV.

ing effect of the valve. The apparatus can be strapped to the patient's chest, and he can let air escape whenever he recognizes the symptoms of respiratory embarrassment due to excessive accumulation of air in the pleural space.

Case Reports: No purpose would be served in describing a series of successfully treated cases in any detail. The apparatus is simple to set up, simple to use, and generally effective. Two cases are here cited because they illustrate two special points. In the first case, the patient was arrested for drunken driving because of his confusion, dizziness, and collapse. In the second, the patient was apparently dead, and

was "revived" by pumping air out of the pleura.

G. S., male, white, aged 26, had been receiving artificial pneumothorax on the right side. After a month, the cavity had collapsed, the sputum had become negative. Eight months later he developed fluid on that (right) side, and for a year it was necessary to remove it weekly, replacing it with air. At this time a cavity developed on the left side. I collapsed this lung, and for some months I was replacing fluid with air on the right, and introducing air refills on the left. One day after receiving pneumothorax on the left side, he walked out of the office, apparently well. While driving home

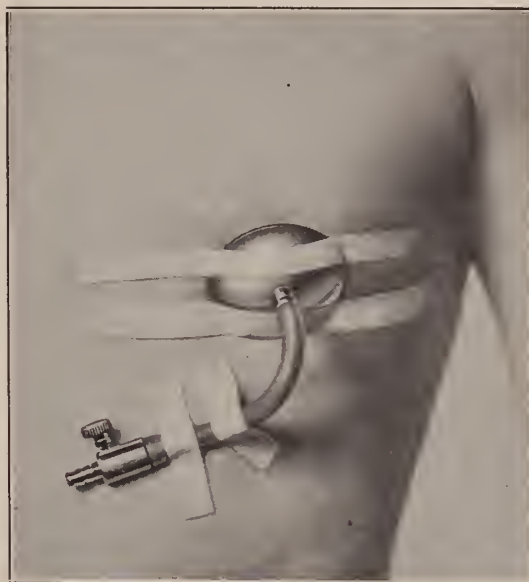


FIGURE V.

he became dizzy, confused, and weak, and then collapsed. Arrested for "drunken-driving", he was taken first to a police station, then to the hospital. He managed to gasp my name, and at a call from the police, I went to the hospital where I found him cyanotic and almost breathless. Pulse was scarcely detectable. On the left side I performed the procedure described above under "*emergent technique*", pumped air out of the pleural cavity, and then attached the second apparatus described under "*non-emergent technique*". He remained two days in the hospital, returned home, the valve and needle still strapped to his chest. He was told how to operate it, and during the next three days had occasion to release the air once. Three days later I found the pleural pressure negative, and removed the needle, shield, and valve. It was then possible to continue artificial pneumothorax on the left side, and his subsequent course has been uneventful.

S. E., male, white. In 1925 this man—then 29 years old—had a well-developed case of pulmonary tuberculosis. I was first called to see him because of hemorrhage. Sputum was positive, and a cavity

at the left apex, diagnosed clinically, was confirmed by x-ray. I administered artificial pneumothorax, and after four refills the cavity in the left lung collapsed. His sputum eventually became negative, pneumothorax was discontinued, and in 1927 the lesion was considered arrested.

In 1937 another hemorrhage occurred, and sputum was found to be positive. X-ray and clinical evidence indicated a cavity at the right base. After six months of right-sided artificial pneumothorax, this cavity collapsed, sputum became negative. At this time, however, a cavity appeared at the left base. I now collapsed the left side, but continued the right-sided pneumothorax. After the fifth treatment, he returned home as usual, only to notice severe dyspnea. I was called, and before I reached the patient's home, a second call had been transmitted to my office that the man was already dead. On arrival I found him cyanotic and breathless. Corneal reflexes were absent, pupils failed to react to light, pulse was imperceptible. Only a feeble heart-beat indicated that life still went on. I inserted the syringe on the left side, using the above described *emergent technique*. As air was pumped out of the pleura, breathing returned, pulse improved. I detached the syringe and fastened the blood-pressure valve using the "*non-emergent technique*". After four days, pleural pressure was negative, and the apparatus could be removed.

Comment on the Cases: The emergency spontaneous pneumothorax occurred in both cases on the left side. This is the usual rule. The second case is interesting because it was possible to re-collapse a lung after fourteen years. The first patient presented some of the clinical symptoms of drunkenness, though of

course there was no alcoholic odor to his breath. However, the incoördination was sufficient to convince a police officer that the patient was intoxicated.

SUMMARY AND CONCLUSIONS

1. Spontaneous bilateral pneumothorax is a medical emergency requiring swift mechanical treatment directed towards the immediate relief of the pressure on the heart, lungs and mediastinum.
2. A secondary treatment aim is the maintenance of negative pleural pressure with the hope of healing the fistula.
3. A "continuous flow" syringe set up in reverse can be used for exhausting the air in the pleura, thus accomplishing immediate relief of pressure symptoms.
4. A sphygmomanometer valve, set up in reverse can be used to maintain negative pleural pressure.
5. The technique for performing these procedures is described and illustrated.
6. Two cases are cited demonstrating the effectiveness, practicability and simplicity of the procedure.

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INCLUSION BLENNORRHEA

By HAROLD D. BARNSHAW, A.B., M.D., Camden, N. J.

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Read before the Section on the Eye, Ear, Nose, and Throat of the Annual Meeting of The Medical Society of New Jersey on June 6, 1940.

The purpose of this paper is to bring to your attention a clinical entity, inclusion conjunctivitis, which is important to diagnose because the advent of sulfanilamide therapy has offered almost a specific remedy.⁶ This disease is a type of conjunctivitis mostly found in the newborn, but also present in adults. Thygeson presented a thorough report of this disease in 1936.³

Since Halberstaedter and Prowazek first dis-

covered inclusion bodies in cases of trachoma, there has been much discussion as to their specificity.⁵ Stargardt in 1909 first reported inclusion bodies in various ocular conditions other than trachoma. Many investigators have felt that inclusion blennorrhoea is really trachoma, and that they both are of genital origin. The recent investigators have disproved this because in cases of inclusion blennorrhoea the typical pannus of trachoma never forms, the fibrous

contracture of the conjunctiva and the loss of the cul-de-sac never occur and the duration of the disease is shorter.

Other investigators have felt that it is a type of gonorrheal infection because in gonorrheal conjunctivitis inclusion bodies are often found. This also has been disproved because they were not found in every case of gonorrheal conjunctivitis and because in the cases of typical clinical inclusion blennorrhea the inclusion bodies are always found.

Inclusion blennorrhea is caused by a virus infection, and is a venereal disease. The baby becomes infected while passing through the birth canal. The inclusion bodies have been recovered from the cervical epithelium of women whose babies have been infected. If the husband is interviewed, he will often give a history of some urethral or prostatic infection which often has not been proved gonorrheal. Thygeson reported a case of a gynecologist becoming infected when secretions from a cervix he was treating splashed in his eye.³

EXAMINATION OF SPECIMENS

The specimens for staining are obtained by rubbing a knife gently across the palpebral conjunctiva of the lower lid until it just bleeds. These scrapings are placed on a slide and stained. They may be stained with Giemsa stain, as used by Halberstaedter and Prowazek; but Wright stain does just as well. This was suggested to me by Dr. William T. Read, and I found in looking over the literature that Julianette and Verhoef had used the same stain. It is used in the same manner as staining a blood smear. The stain is applied for one minute, and then diluted with distilled water until a metallic lustre is noted on the surface. This is allowed to stand for four minutes and then the slide is washed and dried. The inclusion bodies are found as granules in the epithelial cells, often clustered around the nucleus, and at times found free between the cells. The granules of inclusion bodies are basophilic, and must be differentiated from the neutrophilic granules normally found in epithelial cells. The red granules are known as *elementary* bodies, and the blue granules as *initial* bodies.

SYMPTOMS

Generally about four to seven days after delivery, which is the incubation period, one or both eyes of the infant are markedly swollen, with a large amount of serous exudate. The lower lid is markedly reddened and thrown into folds. The inflammation is often confined to the lower lids, and this makes the ophthalmologist suspicious of the true condition. In adults it is generally a follicular conjunctivitis. Smears are taken at once, and then conjunctival scrapings.

It is differentiated from bacterial conjunctivitis clinically by being confined to the lower lids, the reaction being less acute; and finally by the smears. In congenital stenosis of the nasolacrimal duct, the differentiation is not difficult. There is marked epiphora; and after dilatation of the punctum, a solution cannot be irrigated into the nose. After breaking through the epithelial barrier with a small probe the solution is easily washed into the nose. In adults it is differentiated from trachoma by the lack of pannus and cicatricial contractures of the conjunctiva.

The advantage of making the diagnosis is that the doctor may tell the parents that the eyes will not be injured,² and sulfanilamide may be given to shorten the length of the disease. Before the advent of sulfanilamide, the condition in a child would take from three to four months to clear; and in the adult from three months to a year.

PREVALENCE

The disease is apparently somewhat rare in the East. Thygeson reported its occurrence thirty-four times in 261 cases of ophthalmia neonatorum occurring in 3,939 newborn.² We have discovered only four cases in the last four years. One of these was in an adult. Two were from the Cooper Hospital where about 5,000 babies have been delivered in the last four years; and one was from the Zurbrugg Hospital, Riverside, N. J. I believe with our increased index of suspicion we will discover more.

TREATMENT

The local treatment follows the line of the treatment of ophthalmia neonatorum. At the

Cooper Hospital, Dr. Shipman has always treated his cases of conjunctivitis in babies as a very serious condition; and the type of the organism only tends to indicate the general treatment;—the local treatment is the same for all.

The patients are isolated with a day and night nurse. The nurse is instructed to irrigate the eyes every half hour, and to place ice compresses on the lids for thirty minutes every hour. Aqueous mercurochrome, one per cent, or argyrol, 20 per cent, is dropped into the eyes every four hours. The doctor visits the patient once or twice a day, at which time he paints the lids with silver nitrate, one per cent. If the cornea becomes hazy, the compresses are changed to hot. This very seldom happens. Of the cases treated at the hospital no eyes have been lost. It is generally conceded that, after a diagnosis of inclusion blennorrhea has been made, the treatment should be modified, stopping the use of silver nitrate, and using one per cent aqueous mercurochrome three times a day.

SULFANILAMIDE

The ordering of sulfanilamide should be left in the hands of the pediatrician. It is generally given in milk, daily, according to the weight of the child, in about the dosage of one-half to one-third grain, with daily check on the red blood count. In adults it may be given in dosage of ten grains, three times a day, with a weekly check on the red blood count. This should be continued for about two weeks; then five grains are to be used three times a day for another two weeks. Usually the condition appears much better at the end of the first week; and by the third week is completely healed.

CASE I

On the fourth day after birth the eyes became red and congested, with conjunctival hypertrophy. Smears were negative. Treatment alleviated the acute symptoms, but the eyes entered a chronic phase. At Dr. Shipman's suggestion a scraping was taken and examined at the Wills Eye Hospital, where many inclusion bodies were found. Zinc sulphate was instituted in the treatment, and the child got well in about three months, without any residual effects.

CASE II

Baby delivered at the Zurbrugg Hospital. Doctor consulted me by telephone; and from the descrip-

tion he gave, I suspected inclusion blennorrhea; and scrapings at the Cooper Hospital were positive for inclusion bodies. The baby had a marked follicular conjunctivitis of both lower lids. Condition cleared up without any residual effects after three months' treatment.

CASE III

Baby delivered at the Cooper Hospital and referred to the eye clinic because of a low grade conjunctivitis. Examination showed marked hypertrophy of the conjunctiva of both upper and lower lids. Scrapings showed a few inclusion bodies. The baby was discharged, cured, after two months of local treatment.

CASE IV

M. M., aged 53, reported to my office on October 16, 1939, complaining of a sore left eye. Examination revealed a markedly congested and hypertrophied conjunctiva, mostly confined to the lower lid. With silver nitrate applications and a zinc wash, she improved greatly. On October 31, 1939, she returned to my office with an exacerbation of the conjunctivitis. At this time smears and scrapings showed many inclusion bodies. The patient was told that her condition would take a long while to clear up, but that she would recover and there would be no sequellae. The patient gave no history of having been in a swimming pool.

On the next visit the patient complained of pain in the eye and a low grade uveitis was found, few deposits on Descemet's membrane, and a few cells in the anterior chamber.

On February 17, 1940, the conjunctivitis continued, and the patient was placed upon ten grains of sulfanilamide, three times a day; and this was continued for four weeks with a weekly check on the blood count. The patient felt better immediately, and the conjunctiva became normal on March 18, 1940, when the patient was discharged.

SUMMARY

Inclusion conjunctivitis is a virus infection, and is diagnosed by scrapings containing inclusion bodies. It leaves no sequellae, and its course may be shortened by the use of sulfanilamide. Four cases have been reported, and one treated with sulfanilamide.

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MEDICAL SERVICE ADMINISTRATION OF NEW JERSEY

Complete information relative to the organization of Medical Service Administration and its plans has been published in previous issues of this *Journal*. Your attention is invited particularly to the announcement distributed as a supplement to the February issue.

FARM SECURITY PLAN

This Plan is in full operation, with about 1800 beneficiaries. Most of these reside in counties south of Trenton. There are no beneficiaries under this Plan in Passaic and Hudson Counties, and very few in other northern counties.

FEES OF FARM SECURITY PLAN—The subscription rate of this Plan should afford a fee schedule of \$1 for office calls and \$2 for house calls. Many of the bills so far received for services rendered during May are for \$1.50 to \$2.50 for office calls and \$3 for house calls. The subscription rate cannot support these fees. It will be necessary to reduce them to \$1 for office and \$2 for house calls. The entire income to physicians under this plan is about \$4500 per thousand beneficiaries, probably considerably more than previously paid by this group of patients. Bills rendered for services to these beneficiaries will be submitted to the County Advisory Committees on June 11 for approval prior to the meeting of the Board of Governors of the Administration on June 22. Checks in payment will be mailed immediately after the meeting of the Board of Governors.

INITIAL SERVICE REPORTS

The very satisfactory return of Initial Service Reports has been of great assistance to the office of the Administration in determining in advance the approximate liability for the month. It has been of assistance on several occasions to physicians rendering the service, as we are able to inform the physicians submitting the report as to the eligibility or non-eligibility of his patients. Initial Service Reports are applicable not only to the Farm Security Plan, but to all plans operated by the Administration. A facsimile of the Initial Service Report appears in this section of the *Journal* (Figures 1 and 2).

PHYSICIANS' STATEMENTS

Physicians' statements must be received by the tenth of the month following that month in which services were rendered. Under the regulations of the Farm Security Plan, bills not received by that time are subject to a reduction of one-third. In designing the physicians' monthly statements, every effort has been

made to simplify the work of the physician. Certain data are necessary to maintain proper records in this office and to satisfy the regulations of the Commissioner of Banking and Insurance. After a short perusal of this statement, we feel that physicians will have no trouble in understanding its details. It is applicable in rendering bills under any of the plans operated by the Administration. A facsimile of this statement is reproduced in this section of the *Journal*, as Figure 3.

IDENTIFICATION CARDS

Each subscriber under any plan operated by the Administration will be furnished with an identification card (see Figures 4 and 5.) On this card will be found the data necessary for the completion of Initial Service Reports and physicians' monthly statements. On this card also will be shown the names of dependent beneficiaries. The Farm Security Plan identification card is printed on white paper. The identification cards of the other plans will be printed on colored paper.

THE INDUSTRIAL PLANS

Plans No. 1 and No. 2, the voluntary plans applicable to industrial employees, are now being introduced. The general response of industry is one of interest. The most common criticism from industrial organizations is that the plans are not applicable to a sufficient number of their employees because of the present high income of industrial workers. The Administration is impressed with the amount of educational work which will be necessary before a widespread application of these plans is possible.

MEDICALLY INDIGENT PLAN

The Board of Trustees and the House of Delegates have approved the following plan as applicable to the truly medically indigent persons of New Jersey. This applies to families with total family incomes of less than \$1300 a year. It is estimated that, in New Jersey, such families contain about one million and a quarter individuals, most of whom receive most of their medical care in public clinics. Under this Plan, the income to physicians will be approximately \$5400 per year per thousand beneficiaries, which is probably more than is now received from this group and sufficient to provide an adequate type of medical care in the homes of these people and the offices of physicians.

The Plan is particularly adaptable to many

INITIAL SERVICE REPORT

(To be filled out when services are first requested)

— WRITE OR PRINT PLAINLY —

----- (*Name of Patient)	----- (*Name of Subscriber)	----- (*Contract Number)
Date on which services were first requested -----, 194....		
Diagnosis ----- -----		
Remarks ----- -----		

*Take information from
Identification Card.

(Signature of Doctor)

(Street)

(City)

(County)

MAIL PROMPTLY TO—Medical Service Administration of New Jersey, 143 East State St., Trenton, N. J.

FIGURE NO. 1

TO THE DOCTOR:

This report serves two purposes:

IT BENEFITS YOU for we check the name of the patient
and inform you if patient is not in good standing.

IT BENEFITS US by informing us of our expected liabilities
for the current month.

We will appreciate your co-operation.

MEDICAL SERVICE ADMINISTRATION OF NEW JERSEY.

FIGURE NO. 2—This is the reverse side of Figure 1.

MEDICAL SERVICE ADMINISTRATION OF NEW JERSEY

143 EAST STATE STREET

TRENTON, N. J.

PHYSICIANS MONTHLY BILL COVERING

Services Rendered This Patient During Month Of _____ 194__.

1 NAME OF PATIENT

2 NAME OF SUBSCRIBER

3 CONTRACT NUMBER

4 DIAGNOSIS:

CALLS	ENTER HERE NUMBER OF CALLS UNDER DAY OF MONTH																															AMOUNT OF CHARGE	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31		
5 OFFICE																																	\$
6 HOME																																	
7 HOSPITAL																																	

SPECIAL SERVICES (Give Details)

DATE

WHERE
RENDERED
☐ OFFICE ☐ HOME ☐ HOSP.

8 OPERATION

9 CONSULTATION

10 X-RAY

11 LABORATORY

12 REMARKS AND/OR
OTHER SERVICES

13 * NAME OF
HOSPITAL

14 TOTAL CHARGES FOR SERVICES RENDERED

15 PATIENT
REFERRED TO

17 REFERRED FOR
☐ TREATMENT ☐ X-RAY

16 PATIENT
REFERRED BY

☐ OPERATION ☐ CONSULTATION

IMPORTANT

MAIL TO MEDICAL SERVICE ADMINISTRATION IMMEDIATELY AFTER DISCHARGE OF PATIENT. IF TREATMENT IS CONTINUED BEYOND THE END OF THE MONTH, MAIL THIS REPORT ON THE LAST DAY OF THE MONTH.

- ☐ NEW CASE
☐ CONTINUED FROM LAST MONTH
☐ FURTHER TREATMENT NEXT MONTH
☐ CASE ENDED

Signature of Doctor

Street

City

County

DO NOT WRITE IN THIS SPACE

GROUP NO.	CONTRACT NO.	PAT	CLAIM NO.	DOCTOR	DATE INCD	OFF	HOME	HOSP	TOTAL	TYPE	DIAGNOSIS	AMT. CHARGE	CRG. ALLOWED


Medical Service Administration of New Jersey 143 East State Street Trenton, New Jersey Subscriber		Identification Card
<h1 style="margin: 0;">SPECIMEN</h1>		
Contract No.	Plan No.	Expiration Date
The Subscriber and Dependents named hereon are entitled to services under above specified contract, up to and including the expiration date.		
(See over)		 <small>EXECUTIVE SECRETARY</small>

FIGURE NO. 4

TO OUR SUBSCRIBERS: To obtain services, present this card to a participating physician.

TO PARTICIPATING PHYSICIANS: Note Plan under which the subscriber is entitled to benefits.

Plan I —Professional care in home, office, or hospital.

Plan II —Professional care in hospital only.

Plan III—Professional care in home and office, rendered to Farm Security clients only.

It is to your advantage to render an initial service report on all new cases.

TO ALL CONCERNED: Full co-operation of all will assure a satisfactory service.

Not valid unless signed by subscriber to whom this card is issued
(Not transferable.)

FIGURE NO. 5—This is the reverse side of Figure 4.

residents of Federal housing projects, W. P. A. employees, and unskilled workers. It is hoped that in certain instances this Plan may be adopted by municipalities for the care of their indigent sick.

Enrollment will be by preestablished groups only, all of which must be certified as to income status by a recognized agency. These groups will be enrolled as families and must include all members of the family except those entitled to medical care under the Social Security Act. Fifty per cent of any such group must be enrolled to assure a cross-section of health.

Subscription rates were estimated on the expected morbidity rate, birth rate, and average number of calls per illness among the indigent. The annual subscription per family will be \$22.80, regardless of the size of the family. On this subscription rate, the plan should pay \$1 for office calls and \$2 for house calls. Payment will not be made for cases admitted to hospitals. These patients must be considered medically indigent in case of serious illness. Effort will be made to refer these patients to

the proper hospital for treatment of serious illness. These people, while medically indigent insofar as payment for major illnesses and consultations is concerned, should be able to afford a contribution which will, in part, support the medical profession and make available prompt and adequate medical care.

By the operation of this Plan, the distribution of medical care to these persons will be improved at a cost within their ability to pay. Other plans operated by the Administration, with the exception of the Farm Security Plan, will not be of particular benefit to those younger physicians who in the past have depended upon the low-income groups during the early years of practice. This Plan should assist this group of physicians.

The Administration has been considering such a Plan for a considerable length of time. Its actual formulation was prompted by the specific request of a Federal housing group anxious to obtain medical care at a cost within their ability to pay, and by which they might be assured of the free choice of physician.

PUERPERAL SEPSIS

MATERNAL WELFARE ARTICLE NUMBER FIFTY-NINE

By ARTHUR W. BINGHAM, M.D., East Orange, N. J.

Statistics show that one of the chief causes of maternal mortality is *sepsis*. The treatment of puerperal sepsis is still quite unsatisfactory in spite of sulfanilamide and allied preparations. Therefore, every effort should be made to prevent infection.

Let us consider briefly how the patient became infected.

Perhaps you failed to wear sterile rubber gloves when making a vaginal examination.

Perhaps you failed to scrub your hands thoroughly before using a sterile glove which later was found to have a minute hole in it.

Perhaps you made a vaginal examination before the patient was sufficiently prepared.

Perhaps you were in a hurry to get to the office, and did not take time for the proper routine.

Perhaps you failed to wear a mask while examining and delivering your patient. The mask is especially important if you have a cold.

Perhaps you touched some non-sterile object after putting on your sterile gloves.

Perhaps in a precipitate birth you treated the baby which was lying on a non-sterile sheet then failed to change your gloves before taking a few sutures or treating the mother in any way.

Perhaps you made a vaginal examination at your patient's home without proper precautions to see if she was in labor before going to the hospital. The patient then enters a hospital where all precautions are taken, but she is already septic, and no one knows why.

Perhaps your patient was draped with sterile towels which shifted with every move, making

it almost impossible to keep from touching a non-sterile area. Patients should be draped so that this cannot occur. Care should be taken not to touch the drapes, especially if they are wet.

Perhaps you were obliged to deliver your patient in a dirty room unfit for such work. Such patients must be educated to go to a hospital or maternity home properly equipped for maternity cases.

Perhaps the "Sterile" equipment used was not really sterilized.

Perhaps you allowed your patient to continue too long in labor before doing a cesarean. The best time to decide to do a cesarean is a short time before labor starts. More preventive prenatal care, with closer study of the case, will help.

Perhaps in a case of hemorrhage in the home, in the emergency you tried to pack the uterus or vagina without having the proper sterile supplies or instruments.

Perhaps many a break in technic has brought no serious results; but is that any excuse to be careless when the majority of cases of puerperal sepsis are caused by such breaks?

Perhaps your patient infected herself either from outside, or from an existing infection—a ruptured appendix, gall-bladder, tubo-ovarian abscess, tonsillitis, or infected teeth. This so seldom happens that it is only a minor cause of puerperal sepsis.

When puerperal sepsis occurs, it is the attending physician's duty to check every step taken and see where a break in technic may have occurred, so as to prevent it next time.

A LESSON FROM A DEATH CERTIFICATE

NUMBER THIRTY-ONE

Patient had a history of three difficult labors, two of which resulted in stillbirths.

With this pregnancy she was in labor six hours then section performed.

On third day signs of sepsis appeared. With this history was it necessary to have a trial labor?

A. W. BINGHAM, M.D.

STATE SOCIETY ACTIVITIES

HADDON HALL HIGH-LIGHTS

Cannon on the boardwalk, and anti-aircraft maneuvers: trench mortars and army-lorries: here was the backdrop for our 175th Anniversary Meeting. While outside, the 44th Division fought a mock battle for the defense of the Atlantic City shore-line, the doctors of New Jersey crowded Haddon Hall for their part in the war against disease. Never before had a meeting of The Medical Society of New Jersey been punctuated by an army in action.

TUESDAY AFTERNOON

Dr. Ferdinand C. Dinge outlined the technique of distinguishing one peripheral vascular disorder from another. No mere academic difference is this, for it matters much whether the peripheral vessel is failing to function by reason of spasm or by reason of embolus. What these various treatment techniques were, and how to apply them were the points of information given by *Dr. B. S. Troedsson*. One method of affording relief from pain due to gangrene of the extremities, according to *Dr. Harold Hantman*, is the exposure and crushing of the peripheral nerve. And if the peripheral pain is due to thrombophlebitis, *Dr. Stuart Z. Hawkes* recommends injection of the spinal sympathetic ganglia. He described his results in 20 cases of phlebitis: prompt relief from pain and swelling. The emotional factors in the development of peripheral vascular disorders were emphasized by *Dr. Johannes F. Pessel*. Finally, *Dr. Irving S. Wright* critically summarized and evaluated the papers of the afternoon. Most of these papers will be published in early issues of *The Journal*.

TUESDAY EVENING

Tuesday evening members of Selective Service Headquarters met with the Society to talk over problems raised by the medical examination of selectees. Only half of the 23,000 registrants examined by New Jersey boards were meeting the rigid requirements of America's peace-time army, said *Major A. M. K. Maldeis*, Chief of the Medical Division of the Selective Service System in New Jersey. Dental defects caused 3,300 of the 12,000 rejections, with eye disorders accounting for another 1,800 cases.

Dr. William J. Carrington asked to what extent the government would support an Atlantic City otologist now threatened with a damage suit because, after washing wax out of

a registrant's ear, a perforated drum was discovered. *Major Edgar Shattuck*, of the Legal Division of National Selective Service system, explained that the government was ready to supply counsel and legal assistance to any doctor plunged into a malpractice suit as a result of his draft-board or induction-board activities. Major Shattuck pointed out, however, that the government had no advance funds appropriated to meet judgments, but gave it as his opinion that if an award should be granted by a jury (and remain on appeal), Congress would probably vote a special appropriation to indemnify the defendant.*

Colonel Leonard Rowntree, Medical Director of the National Selective Service System, explained that the rejection rate was no cause for alarm, pointing out that the country could afford insisting on an army as near to 100 per cent in physical fitness as possible. He urged local boards to record all pulse and blood-pressure figures, suggesting that registrants were usually less excited in their familiar home-town atmosphere (when examined by draft boards) than in the strange environment of a camp or armory (when examined by induction boards).

WEDNESDAY MORNING

Effective results secured by treatment of rickets with a single massive 600,000 unit dose of vitamin D were reported by *Dr. Israel J. Wolf* of Paterson, who read the essay for which he was awarded the Medical Society's prize. Dr. Wolf used a form of ergosterol activated by electrical charge.

The remainder of the morning was devoted to a unique symposium on the health implications of New Jersey's public agencies. *Dr. J. Lynn Mahaffey*, Director of the New Jersey Department of Health, characterized the medical profession as the "rock-ribbed foundation of all public health programs" and described the ways in which the activities of his department meshed with the work of the private practitioner. He urged wider use of the Department's social service facilities in following up cases of venereal infection and gave assurance that such a procedure would not affect the

* This appears to be the usual procedure whenever a judgment is secured against a government officer. In those cases, the city, state or federal government customarily votes a special appropriation to indemnify the defendant, as funds are ordinarily not set up in advance for this purpose.

privacy of the doctor's relations with his patients.

Custodial care for the criminal, the insane, the epileptic and the feeble-minded, was branded as the most expensive kind of care a state could give in its wards, in an address by *William J. Ellis*, Commissioner of Institutions and Agencies of New Jersey. His department's goal, Commissioner Ellis explained, was curative, not custodial. In its health aspects, the Department was striving to preserve the doctor-patient relationship; the State Board of Children's Guardians, for instance, allowed wide latitude in the choice of physicians for the care of its non-institutionalized children. In many ways, the Department was using medical practitioners in their capacity as private physicians; and the ability of a public agency to use private citizens in this way was described as an important element in the democratic process.

Dr. Ellen C. Potter, Director of the Division of Medicine of the State Department of Institutions and Agencies, described how medical care was rendered through state agencies, without any socialization of medical practice. She invited the placement of young graduate medical students in state institutions as summer interns and residents, pointing out that a record of 3,000 minor and 500 major surgical operations a year was a token of the large-sized medical and surgical program carried on in these institutions. Dr. Potter also explained that standards of medical care in the 234 private sanatoria and nursing homes, supervised by her department, were major determinants in the department's decision to approve or renew licenses for such institutions.

New Jersey was described as a pioneer state in teaching the crippled child or adult to help himself, in a talk by *Joseph G. Buch*, Chairman of the state's Crippled Children's Commission. This was the first state to require reporting of all babies born with visible deformities. These reports are confidential and not part of the public birth certificate. The educational, vocational and job-placement program of the Commission was outlined by Mr. Buch, who reported that every adequately trained crippled adult had been placed in a job. The cooperation of the Rotary and Kiwanis clubs in this activity was warmly commended.

Speaking for the New Jersey Tuberculosis League, *Dr. B. S. Pollak* described the educational and case-finding program of the league, and outlined the way in which it geared its activities into the work of the organized medical profession. Physical and mental examination of automobile drivers was urged by *William J. Deardon*, Deputy Commissioner of

Motor Vehicles, who reported that the public has been making increasing demands for this type of examination. More than 100 persons a day are killed in motor vehicles accidents in the country, and Commissioner Deardon underscored the fact that too often a remediable defect of the vision, hearing, coördination or other physical or mental resource of the driver played a rôle in the tragedy. Periodic re-examinations in which the medical profession would have a major part were urged.

The encroachment of governmental hospitals on the domain of the private practitioner was deplored by *Dr. Ellis Smith*, Medical Director of the Essex County Isolation Hospital. Dr. Smith also condemned a growing move to provide private accommodations in municipal hospitals. The rôle of the hospital in graduate medical education was stressed. Dr. Smith spoke of the "flat-rate" hospital plan, and criticized the tendency of a few physicians, whom he characterized as "medical prima donnas", to abuse the policy by calling for unnecessary laboratory work and unneeded equipment.

WEDNESDAY AFTERNOON

Wednesday afternoon was devoted to a practical analysis of diagnostic problems in acute diseases of the abdomen. The proper technical approach to a questionably "surgical" abdomen was discussed by *Dr. Robert S. Gamon*, who put emphasis on the rôle of bed-side diagnosis with a warning not to shift the diagnostic responsibility to the laboratory. Dr. Gamon felt that while persistent abdominal pain for six hours usually indicated need for surgical intervention, a six-hour period was often a tragic delay. The importance of rectal examination and abdominal auscultation in clinical diagnoses of acute abdominal pain was stressed by Dr. Gamon.

Unnecessary delay in making a working diagnosis of an acute abdominal disorder was described as "the unpardonable sin of surgery" by *Dr. William J. Carrington*, who pointed out that to postpone action until diagnosis was 100 per cent certain might be "to sacrifice life on the altar of statistical perfection". Like Dr. Gamon, Dr. Carrington put stress on the clinician's judgment and warned against over-emphases on mechanical and laboratory methods of diagnosis. Peritoneoscopy he condemned as "brutal and futile", explaining that the "resulting keyhole view of the abdomen is unsatisfactory to even the most ardent Peeping Tom".

The general practitioner, said *Dr. Royal A. Schaaf*, "is no longer the vanishing American". Eighty per cent of all ills can be handled by the general practitioner. But one area in which

the family doctor has not come through with flying colors is in the care of appendicitis. Since properly handled, appendicitis mortality should approach zero, the record of 20,000 deaths a year from this disorder justifies a reevaluation of our diagnostic techniques. Appendicitis deaths, Dr. Schaaf felt, were usually due to delay, which in turn arose from self-medication and ignorance on the part of the public. This points up the need for a vigorous educational campaign. In particular, Dr. Schaaf called attention to atypical clinical pictures in appendicitis, notably as found in the aged where onset was usually insidious.

Speaking on gastro-intestinal ulcers, Dr. *Manfred Kraemer* advised that all patients with ulcer of the stomach should be hospitalized. Medical treatment, he suggested, should be the rule, at least for early cases, unless perforation, hemorrhage or obstruction demanded prompt surgical intervention. The death rate, he reported, was lower in medically treated gastric ulcers than in those subjected to operation. Medical treatment should be given three weeks' trial, and if no substantial healing occurs, surgical intervention should be considered. Duodenal ulcers do not demand such prompt surgery, since unlike gastric ulcers, they never become malignant. Treatment of duodenal ulcer is largely a problem in patient-education.

Note: Many of the papers will be published in full in subsequent issues of this *Journal*.

WEDNESDAY EVENING

A huge birthday-cake commemorating the Society's 175th Anniversary ornamented the grand ball-room of Haddon Hall on Wednesday evening. With Past-President William J. Carrington as toastmaster, and retiring President and Mrs. Watson B. Morris as guests of honor, the dinner party rolled on gleefully from the melon at 8:00 p.m. to the last strains of "Home Sweet Home" at midnight. The evening was featured by a quiz contest on medical history, first prize being won by Dr. Reeve Ballinger of Arlington. A quintet of "stooges" wandered through the ball-room, thrusting small microphones before startled guests, as the Toastmaster, in the best Doctor Quiz manner, poured out questions studded with characteristic Carringtonian wit. Highspot of the evening was a review of 175 years of New Jersey medicine, given by Dr. Morris, dramatized by a number of lantern slides illustrating the persons and places famous in our state's medical history. Past-President Spencer Snedecor then presented Dr. Morris with his well-earned Fellow's Key. Dr. Thomas K. Lewis, incoming President, delivered a brief

introductory address to the accompaniment of unexpected but vociferous harmony from the corner table labelled "Camden County". The evening raced on rapidly, and even the gloomiest guest had to confess that there was never a dull moment at Haddon Hall that night.

THURSDAY MORNING

Reviewing his administration, Dr. Morris, retiring President, named the Medical Service Administration and the Medical Preparedness activities as the conspicuous achievements of the 1940-1941 year. Dr. Morris praised the Legislative Committee's successful resistance to the McClave Act Repealer, and characterized the work of the Maternal Welfare Committee as an activity which, in the maternal field, "had made New Jersey the envy of the world". The effective work of the Committee on Post-Graduate Education was also lauded by the retiring President.

Dr. Lewis opened his administration with an address in which he advised the profession to stop talking about socialized medicine in the abstract, urging that now was the time to do something concrete. Warning that new methods of distributing medical care might appear necessary after the conclusion of the present world debacle, Dr. Lewis insisted on clinging fast to two fundamental principles: high-grade care universally available; and no impairment of the free practice of medicine. Dr. Lewis pointed out that just as our American democracy is a model for the world, so our free and democratic method of distributing medical care must be a world demonstration of what can be done in an unregimented commonwealth.

The meeting was closed by the reports of the fifteen reference committees which gave their analyses of the committee reports.

Included in the resolutions adopted by the House of Delegates that morning were decisions to send copies of *The Journal* to our legislators, to set our annual dues at \$16, to restore section meetings to the Annual Meeting program, and to recommend an analytic evaluation of the work of hospital out-patient departments. The reports of these reference committees will be published in full in the *Transactions*, which will be released to all members this Summer.

So ended our Society's seventh quarter-of-a-century of service to the New Jersey public and service to the New Jersey Medical Profession. The 800 doctors who attended will agree that the 1941 Annual Meeting was a panorama of scientific seriousness and social fun, counterpointed by the grim notes of world cataclysm.

THE EXHIBITS

The strongest magnet at Haddon Hall last month was the display of three dozen educational and scientific exhibits. This veritable medical World's Fair formed a perfect complement to the scientific sessions. In the lecture rooms the members were *told* of medical prog-

ress; in the exhibit booths, they *saw* the concrete, visual evidence of such progress. Medical men are all from Missouri. "Show me," they demand when a colleague describes a new instrument, a new technique, a new treatment. And here in the exhibit hall they were shown.

AWARDS

So instructive and so vivid were the numerous displays that the Committee had an admittedly hard time in selecting award recipients.

For Meritorious Individual Investigation

1. *The Fungi: Their Rôle in Respiratory Disease.* Nathan Schaffer, M.D., and Irving L. Applebaum, M.D., Orange Memorial Hospital and Newark Beth Israel Hospital.
2. *Acidosis and Alkalosis. Clinical Measurement and Significance.* W. G. Exton, M.D., and A. R. Rose, Ph.D., Prudential Insurance Company.
3. *Cystoscopic Photography.* Lowrain E. McCrea, M.D., Temple University Medical School.

Honorable Mention

Plastic and Reconstructive Surgery. Morton Berson, M.D., New York.

For Meritorious Excellence

1. *Surgery of the Anorectum with Special Reference to the Avoidance of Pain.* Harry E. Bacon, M.D., and Reginald A. Archambault, M.D., Temple University and University of Pennsylvania, Graduate Schools of Medicine.
2. *Endocrine Lesions and Experimental Creatinism.* Samuel A. Goldberg, M.D., Presbyterian Hospital, Newark.
3. *Classification and Treatment of Carcinoma of the Breast.* Milton Friedman, M.D., and Benjamin Copleman, M.D., Newark City Hospital.

HERE IS A QUICK TRIP THROUGH THE EXHIBIT HALLS

EDUCATIONAL EXHIBITS

Library of the Academy of Medicine of Northern New Jersey

In a comfortably carpeted, book-lined booth, the members were given a chance to see the usefulness of a medical library as a tool of scientific research. Also on display was a step-by-step pictorial analysis of how to use the Index Medicus.

Telling the World—How Your Public Relations Committee Works

COMMITTEE ON PUBLIC RELATIONS OF THE MEDICAL SOCIETY OF NEW JERSEY

Under this title was an exhibit of the functioning of the Speakers' Bureau and of the mechanics of securing press releases. The display illustrated the way in which the requests for speakers are handled through the Public Relations Committee. Also on view was a full page of the Newark Sunday Call, given over

entirely to Medical Society publicity on March 23.

New Jersey Formulary Preparations

JOINT COMMITTEE ON PROFESSIONAL RELATIONS OF THE MEDICAL SOCIETY OF NEW JERSEY AND THE NEW JERSEY PHARMACEUTICAL ASSOCIATION.

A rack of New Jersey Formulary preparations was on display. The advantages to the doctor, pharmacist and patient were dramatized.

Activities of the New Jersey Department of Institutions and Agencies

The State Department of Institutions and Agencies displayed transparencies showing the activities of the correctional and medical institutions under its control. On a large map of New Jersey were marked the sites of these institutions.

New Jersey Department of Health

The New Jersey Department of Health exhibited its promotional posters. Many phases of the work of the department were outlined on a series of baloptican slides. Pamphlets on communicable diseases were distributed.

State Department of Motor Vehicles, Trenton

A vivid presentation of the relation of alcohol to traffic accidents was sponsored by the New Jersey Department of Motor Vehicles. On display was a medical examiner's report form for recording examinations of drunken drivers. Copies of this were distributed to doctors in attendance. Also available was a fact-packed manual for the driver, as well as other pamphlets released by the department.

The Mechanism of Contraception

NEW JERSEY BIRTH CONTROL LEAGUE,
NEWARK, N. J.

A vivid moving picture was exhibited pictorializing the technique of the application of contraceptive measures. The League also displayed charts showing the location of birth control clinics in New Jersey.

The Industrial Physician in National Defense

NEW JERSEY ASSOCIATION OF INDUSTRIAL
PHYSICIANS AND SURGEONS

A display on the relationship of the industrial physician to the national defense program emphasized the importance of periodic examination in maintaining maximum efficiency. The forms used by large industrial corporations in making and recording these examinations were shown.

Much attention was attracted by a mannikin dramatizing the use of a respirator, safety goggles, asbestos gauntlets and other safety equipment.

Committee on Medical Preparedness of The Medical Society of New Jersey

The Committee set up a display showing the team examination methods effectively used by Atlantic City Selective Service Examining Boards.

Also of interest were several posters supplied by the British Ministry of Information, showing the methods of public health education now in use in war-time Britain.

Maternal Mortality Statistics in New Jersey

THE COMMITTEE ON MATERNAL WELFARE
OF THE MEDICAL SOCIETY OF NEW JERSEY

The Maternal Welfare Committee exhibited maps showing the distribution by counties of

the complications of pregnancy and the puerperal period.

New Jersey Tuberculosis League

The exhibit of the New Jersey Tuberculosis League was high-lighted by several three-dimensional displays on the diagnosis and treatment of tuberculosis, and by an x-ray film of tuberculous cavitations.

New Jersey Hospital Association

The New Jersey Hospital Association displayed an illustrated map showing the distribution of hospitals in the state, classified by size.

A panel describing the purposes of the Association was also on view.

Child Welfare in Essex County

CHILD WELFARE COMMITTEE OF ESSEX
COUNTY MEDICAL SOCIETY

The walls of the booth assigned to the Child Welfare Committee of Essex County were adorned with two dozen photographs of Baby Lois, showing various stages of her development.

Special attention was given to the premature baby by displays of clothing, feeding equipment and incubators suitable for the premature. The portable incubator shown at the meeting is the only one of its kind in the East.

Activities of a Pathologist in a Community

AMERICAN SOCIETY OF CLINICAL PATHOLOGISTS,
MUNCIE, IND.

The training of the pathologist was dramatized in chart form by the American Society of Clinical Pathologists, which displayed a transparency showing the types of service a pathologist can provide for the community.

The distribution of 700 members throughout the United States was illustrated on a map.

Registry of Medical Technologists

AMERICAN SOCIETY OF CLINICAL PATHOLOGISTS,
MUNCIE, IND.

The American Society of Clinical Pathologists presented a display of its registry of medical technicians. The training requirements for this profession were well illustrated.

Selective Sterilization for Human Betterment

STERILIZATION LEAGUE OF NEW JERSEY,
PRINCETON, N. J.

Under the auspices of the Sterilization League was a display advocating "selective sterilization for human betterment". Pamphlets dealing with genetics and population problems were distributed.

MEDICAL EXHIBITS

Gastrosocopy

EUGENE MERLISS, M.D., Newark Beth Israel Hospital, Newark, N. J.

Much favorable interest was attracted by this exhibit of gastrosocopy. Full colored paintings drawn from life illustrated gastrosocopic views of the stomach in health and disease. The gastrosocopic pictures were accompanied by films illustrating the x-ray findings as well as by tissue specimens.

Acidosis and Alkalosis—Clinical Measurement and Significance

W. G. EXTON, M.D., and A. R. ROSE, PH.D., Prudential Insurance Company of America, Newark, N. J.

A unique method of determining the extent of acidosis and alkalosis by colorimetric techniques, instead of by the more cumbersome "assay" method was presented. The booth illustrated the equipment used in this process. This exhibit won an award for "meritorious individual investigation".

The Fungi: Their Role in Respiratory Disease

NATHAN SCHAFER, M.D., and IRVING L. APPLEBAUM, M.D., Beth Israel Hospital, Newark, N. J., and Memorial Hospital, Orange, N. J.

In the opinion of the judges, this was one of the blue-ribbon exhibits of the meeting. The display depicted the rôle of fungi in respiratory disease. Fifty-one pure cultures of fungi themselves were shown. Also on view were x-ray films and photographs illustrating the pathologic effects of the fungi in various stages of growth.

Diabetes in the 1940's

ELIOTT P. JOSLIN, M.D.; LOUIS I. DUBLIN, PH.D., George F. Baker Clinic of the New England Deaconess Hospital, Boston, Mass., and Metropolitan Life Insurance Company, New York City.

Experiments made by the Deaconess Hospital in Boston and the Statistical Department of the Metropolitan Life Insurance Co. formed the background for a series of twelve panel displays on diabetes in the 1940's. Pictorialized on charts were mortality rates, insulin schedules, diabetic complications and diabetic diets.

The Blood Bank—Two Years of Successful Operation

WILLIAM ANTROPOL, M.D.; LESTER M. GOLDMAN, M.D.; PHILIP LEVINE, M.D.; M. ASHKENAZY, M.D.; H. SPRINZ, M.D., Newark Beth Israel Hospital, Newark, N. J.

This display of the operation of the blood bank was accompanied by an analysis of the effects of anti-coagulants and the incidence of the various blood groups. The actual operation of the blood bank was photographically illustrated.

Toxicity of Sulfanilamide Derivatives and Organic Lesions Caused by Their Administration

WILLIAM ANTROPOL, M.D.; LESTER M. GOLDMAN, M.D.; H. SPRINZ, M.D.; JACOB CHURG, M.D.; D. LEHR, M.D.; M. KLEIN, M.D., Newark Beth Israel Hospital, Newark, N. J.

The laboratories of the Newark Beth Israel Hospital presented an exhibit of the toxicity of sulfanilamide compounds. Photographs illustrated tissue changes produced by toxic doses of these compounds. Crystals of the sulfanilamide compounds were shown by photographic enlargements.

ENDOCRINE EXHIBITS

Endocrine Lesions and Experimental Cretinism

SAMUEL A. GOLDBERG, M.D., Presbyterian Hospital, Newark, N. J.

This prize-winning exhibit presented an exhaustive display of tissue specimens, photographs and micro-photographs, as well as kodachromes and x-ray films picturing all aspects of endocrinology.

Use and Misuses of Estrogens and Androgens

RITA S. FINKLER, M.D., and ASSOCIATES, Beth Israel Hospital, Newark, N. J.

This was a display of the uses and abuses of estrogens and androgens. A chart warned physicians against the abuse of these products, and listed specific conditions in which they were dangerous. Also shown was a series of photographs illustrating the effects of properly administered sex hormones in endocrine disorders.

PLASTIC SURGERY

Plastic and Reconstructive Surgery

MORTON I. BERSON, M.D., NEW YORK CITY

This was the "Honorable Mention" exhibit of the meeting. Moulages were displayed showing the technique of rhinoplasty. Plastic methods were further illustrated by a series of moving pictures showing actual operative procedures.

Plastic Surgery of Nose and Face

SAMUEL COHEN, M.D., PHILADELPHIA, PA.

This exhibit of plastic surgery of the nose and face was made dramatic by the presentation of several dozen "before and after" photographs, each accompanied by appropriate plaster casts.

Plastic and Reconstructive Surgery of the Head, Neck and Extremities

JACQUES W. MALINIAC, M.D., Sydenham Hospital, New York City, and Beth Israel Hospital, Newark, N. J.

This was an exhibit of plastic repair of the nose, chin and breast and the corrections of bone deformities illustrated by photographs.

Plastic Surgery

JULIUS NEWMAN, M.D., NEWARK, N. J.

This display consisted of a series of "before and after" photographs showing the effectiveness of appropriate plastic surgery in the correction of long nose, bulbous nose, prognathic jaw, retruding jaw, flap ears and fracture of the mandible.

X-RAY EXHIBITS

Esophageal Orifice Hernia—A Clinical-Roentgen Study

LOUIS L. PERKEL, M.D., JERSEY CITY MEDICAL CENTER, JERSEY CITY, N. J.

A clinical roentgen study of esophageal orifice hernia was presented, based on a study of 31 cases, illustrated by roentgen findings and operative results.

Classification and Treatment of Carcinoma of Breast

MILTON FRIEDMAN, M.D., BENJAMIN COPELMAN, M.D., Newark City Hospital, Newark, N. J.

Principles and results of radiation in the treatment of breast malignancies were illustrated in this prize-winning display, featured by "before and after" photographs in color.

Primary Cancer of the Lung—A Radiologic Study

RAPHAEL POMERANZ, M.D., and R. H. DIEFFENBACH, M.D., Newark, N. J.

Sixty-four x-ray films showing primary carcinoma of the lung were extensively and instructively displayed.

Hip and Pelvis—Non-traumatic Roentgen Pathology

RAPHAEL POMERANZ, M.D., Hospital for Crippled Children, Newark, N. J.

This unique series of x-ray photographs showed the pathology of non-traumatic lesions of the hip and pelvis.

SURGICAL EXHIBITS

Osteogenic Sarcoma

THOMAS A. SHALLOW, M.D.; KENNETH E. FRY, M.D., and NED T. RAKER, M.D.
Jefferson Hospital, Philadelphia, Pa.

The Surgical Department of Jefferson Hospital illustrated osteogenic sarcoma by photographs of the tissues and by x-ray pictures. These photographs covered 43 verified cases. The several treatment procedures were outlined and their effects tabulated.

Puerperal Sepsis

NICHOLAS M. ALTER, M.D., Margaret Hague Maternity Hospital, Jersey City, N. J.

This exhibit of puerperal sepsis was illustrated by actual specimens of uteri and adnexa removed at autopsy from victims of this disease. The methods of infection were demonstrated in slides and photographs.

**Proctoscopic Views—Lesions of the Rectum
and Sigmoid**

BENJAMIN HASKELL, M.D., and LOUIS K. COLLINS, M.D., Jefferson Medical College Hospital, Philadelphia, Pa.

The Proctologic Department of Jefferson Medical College set up slides illustrating lesions of the lower bowel as seen through the proctoscope. Observers had a chance to examine the lesions through special eye-pieces.

Cystoscopic Photography

LOWRAIN E. MCCREA, M.D., Temple University Medical School, Philadelphia, Pa.

New Jersey physicians were able to see for the first time, in this prize-winning exhibit, a set of cystoscopic photographs of bladder le-

sions as actually seen through the cystoscopic camera.

**Surgery of the Anorectum—Special Reference to
the Avoidance of Pain**

HARRY E. BACON, M.D., and REGINALD A. ARCHAMBAULT, M.D., Temple University and University of Pennsylvania Graduate Schools of Medicine, Philadelphia, Pa.

The details of the operative steps used by the proctologist were illustrated in a colored moving picture film. The technique was vividly shown in enlarged models, and the operative procedure was illustrated in a series of transparencies. This exhibit won first award for meritorious excellence.

TECHNICAL EXHIBITS

Particularly attention-arresting this year were the fifty technical and commercial exhibits set up by purveyors of drugs, instruments, foods and books. The crowds that circulated through the Exhibit Parlor testified to the members' interest in seeing at first hand so much of the actual material with which doctors work every day. Following is a list (alphabetically arranged) of the technical exhibitors:

Alkalol Company, Taunton, Mass.
Billhuber-Knoll Corporation, Orange, N. J.
Borden Company, New York
Burroughs Wellcome & Co., New York
Cameron Surgical Specialty Co., Chicago
Ciba Pharmaceutical Products, Summit, N. J.
Coca-Cola Company, Atlanta, Ga.
Cook Laboratories, Inc., New York
Davies, Rose & Co., Boston
Doak Company, Cleveland, Ohio
Doho Chemical Corporation, New York
Faulhaber & Heard, Inc., Newark, N. J.
C. B. Fleet Co., Inc., Lynchburg, Va.
Gerber Products Co., Fremont, Mich.
J. E. Hanger, Inc., New York
Hanovia Chemical & Manufacturing Co., Newark, N. J.
Harrower Laboratory, Glendale, Calif.

H. J. Heinz Company, Pittsburgh
Holland-Rantos Co., Inc., New York
Jones Metabolism Equipment Co., New York
Kalak Water Company of New York
Lea and Febiger, Philadelphia
Lederle Laboratories, New York
Lepel High Frequency Laboratories, New York
Liebel-Flarsheim Co., Cincinnati
Eli Lilly & Co., Indianapolis
Mead Johnson and Company, Evansville, Ind.
The Mennen Company, Newark, N. J.
Merck & Co., Inc., Rahway
C. V. Mosby Company, St. Louis
The Muller Laboratories, Baltimore
National Casualty Co., Jersey City
Nestles Milk Products, Inc., New York
Parke, Davis and Company, Detroit
Petrolagar Laboratories, Inc., Chicago
Philip Morris & Co., Ltd., New York
Chas. H. Phillips Chemical Co., New York
Picker X-Ray Corporation, New York
Reed and Carnrick, Jersey City
Schering Corporation, Bloomfield, N. J.
Sharp & Dohme, Inc., Philadelphia
Smith, Kline & French Laboratories, Philadelphia
E. R. Squibb and Sons, New York
Sun Rayed Company, Frankfort, Indiana
Wallace & Tiernan Products, Inc., Belleville, N. J.
The Wander Company, Chicago
White Laboratories, Inc., Newark, N. J.
John Wyeth & Brother, Inc., Philadelphia.

TRUSTEES' MEETING

A regular meeting of the Board of Trustees was held on Sunday, May 11, 1941, in the Executive Offices, Trenton. Ten members were present: Dr. Costello, Chairman; Drs. North, Green, Young, Lewis, Hollinshead, Morris, Marsh, Stahl and Fithian. Drs. Crowe, Alexander, McBride and Norton were excused.

Also present were Drs. Barkhorn, Schlichter, Robbins, Pollak, Sprague, Scott and Wilkes, who acted as Secretary at the request of Dr. Crowe.

PUBLIC HEALTH COMMITTEE RESOLUTIONS

The Public Health Committee's resolutions, as approved by the Welfare Committee, were considered by the Trustees, and the high ideals contained therein were endorsed.

NATIONAL YOUTH ADMINISTRATION

Dr. Robbins, Chairman of the Public Relations Committee, reported that he had contacted Mr. Miller, Director of the NYA, who assured him that he was perfectly willing to coöperate with and be guided by the Medical Society at all times.

MEDICAL PREPAREDNESS COMMITTEE

Dr. Schlichter reported for the Medical Preparedness Committee, and a special meeting is to be arranged at the time of our Annual Meeting in Atlantic City, at which a government representative will discuss with the physicians on local draft boards their legal status.

Dr. Schlichter spoke of the constantly expanding program of the Committee and stated that a full-time stenographer would be required by Dr. Scott, Secretary of the Committee, but

he believed that funds could be found outside of the Medical Society to pay for this service.

MEDICAL SERVICE ADMINISTRATION

Dr. Sprague reported for the Medical Service Administration and asked approval of Plan No. 4, devised to meet the medical needs of persons whose incomes are such that in cases of prolonged illness they quickly become medically indigent unless a low-cost limited service similar to the ERA Plan were provided. The Trustees unanimously approved the plan submitted.

Dr. Scott was lent for another year to the Medical Service Administration, to continue as Medical Director of that project.

RESIGNATION OF DR. OVERTON

The resignation of Dr. Overton as Editor was accepted with regret, and Dr. Henry A. Davidson was appointed as part-time Editor of The Journal on an experimental basis for one year.

BUDGET

The budget for next year will be considered by the Trustees at the Annual Meeting, and presented in final form before the House of Delegates at the opening meeting.

DONATION TO ACADEMY OF MEDICINE

The Trustees voted a donation of \$200.00 to the Academy of Medicine of New Jersey in appreciation of the services given to various committees of the State Society.

LEROY A. WILKES, M.D.,
Acting Secretary.

UNITED STATES CIVIL SERVICE EXAMINATIONS

SENIOR MEDICAL OFFICER, \$4,600 A YEAR
MEDICAL OFFICER, \$3,800 A YEAR
ASSOCIATE MEDICAL OFFICER, \$3,200 A YEAR

Public Health Service, Federal Security Agency
Food and Drug Administration, Federal Security Agency
Veterans' Administration
Civil Aeronautics Administration, Department of Commerce
Indian Service, Department of the Interior

For full information regarding the above examinations write to your County Society Secretary or the Executive Offices, 143 East State Street, Trenton.

WELFARE COMMITTEE

A meeting of the Welfare Committee of The Medical Society of New Jersey was held on Sunday, April 6th, 2:00 p. m., in the Stacy-Trent Hotel, Trenton, Dr. Hilton S. Read, Chairman, presiding.

Those present were:

Atlantic County

Dr. Hilton S. Read, Chairman

Dr. Wm. J. Carrington Dr. David B. Allman

Bergen

Dr. G. Barton Barlow Dr. Joseph R. Morrow

Camden

Dr. Ernest G. Hummel Dr. Henry B. Decker

Dr. Reuben L. Sharp

Cape May

Dr. Clarence W. Way

Cumberland

Dr. Millard F. Sewall Dr. H. Burton Walker

Essex

Dr. Alfred Stahl, Ex-officio

Dr. Arthur W. Bingham Dr. Edgar A. Ill

Dr. Harry N. Comando Dr. Elbert S. Sherman

Dr. A. Charles Zehnder Dr. Charles M. Robbins

Dr. H. Roy Van Ness

Gloucester

Dr. Wendell J. Burkett Dr. Chester I. Ulmer

Hudson

Dr. Reeve L. Ballinger Dr. B. S. Pollak

Dr. A. E. Jaffin Dr. Frederic J. Quigley

Dr. Jos. F. Londrigan Dr. Andrew C. Ruoff

Hunterdon

Dr. Samuel B. English

Monmouth

Dr. C. Byron Blaisdell Dr. Robert E. Watkins

Dr. Stanley Nichols

Morris

Dr. Byron G. Sherman Dr. Franklin W. Rice

Ocean

Dr. J. Edwin Obert

Passaic

Dr. Sigurd W. Johnsen

Somerset

Dr. Frank L. Field

Sussex

Dr. August H. Groeschel

Union

Dr. Watson B. Morris, Ex-officio

Dr. Norman W. Burritt Dr. J. Mallory Carlisle

Dr. L. B. Armstrong

Warren

William H. Varney

Advisory

Dr. Robert P. Fischelis

Mr. William MacDonald

Dr. Samuel Alexander, Trustee

Miss Margaret Ashmun

Dr. Emil Frankel

GREETINGS FROM PRESIDENT MORRIS

President Morris reviewed his program as presented to the House of Delegates on his inauguration as President in 1940, and pointed out some of the accomplishments and the tasks to be continued in the next administrative year. He thanked the Committee Chairmen and members, and the Sub-Committee and Advisory Committee Chairmen and members for their effective support and achievements, and modestly passed on the credit to his associates.

ANNUAL REPORTS

The Annual Reports submitted by the various Sub and Advisory Committees were reviewed and approved for printing and submitting to the House of Delegates. (See May, 1941, Journal.)

RESOLUTION OF ADVISORY COMMITTEE ON TUBERCULOSIS

The following resolution, presented by Dr. Jaffin with the approval of Dr. Nichols and the Public Health Committee, was unanimously approved:

Resolved: That in response to the request of the New Jersey Tuberculosis League on behalf of the State Parent-Teacher's Association for an x-ray survey of their 1,200 members at a meeting in Atlantic City next October, we transmit to the State Medical Society our recommendations as follows:

1. We recognize that a demand already exists by the public for mass x-ray surveys of the chest in the schools and elsewhere.

2. We recognize the value of this procedure in case-finding, but insist that a family physician be named before the x-ray is made, and the report sent to him.

RESOLUTION BY DR. NORMAN BURRITT

A resolution by Dr. Burritt regarding Winthrop Chemical Company's "Sulfathiazole" was referred to a committee consisting of Drs. Harry N. Comando, Chairman; Watson B. Morris, William H. Varney and Norman W. Burritt; and this committee will report to the House of Delegates at our Annual Meeting.

CANCER MOTIONS

The Welfare Committee sent to the Trustees their reasons for approving the Resolutions of the Cancer Committee on February 9, 1941.

Dr. H. B. Diverty, County Society President

Dr. R. J. Faulkingham, County Society President

MEDICAL PREPAREDNESS ACTIVITIES

MUNICIPAL DEFENSE COUNCILS

Recent legislation requires the appointment of a local defense council in each community in New Jersey. To date, 245 such councils have been named. Physicians are urged to participate actively in this work, particularly as members of the health committee of the local Council. The Medical Preparedness Committee of The Medical Society of New Jersey and the Medical Preparedness Committee of your County Society are ready to lend their assistance to physicians formulating municipal health and first-aid programs.

INDUCTION BOARDS

Induction examinations of all New Jersey selectees are now being conducted at the Trenton Induction Station. The Newark Station was closed on May 17, 1941, and the Somerville and Camden stations had been discontinued some months earlier. The induction examinations at all stations in New Jersey had been conducted largely by civilian medical teams, but on June 2, the civilian examiners at the Trenton station were relieved of further duty, and the work was taken over by an examining board composed of medical reserve officers, activated for this purpose.

From November to June, the civilian physicians served during twelve induction periods. They have examined more than 27,000 men. Members of the Tuberculosis Committee of this Society, serving as medical examining teams, making use of portable roentgen apparatus and developing rooms, have x-rayed the chest of every selectee passing through the station. Each film was interpreted and the findings recorded on the examination form of each man on the day of his examination and prior to swearing-in.

The contribution of these civilian physicians has received high praise from War Department officials, and is cited as a recognized credit to the medical profession of New Jersey.

LOCAL HEALTH PROGRAMS

Many physicians have requested advice and assistance relative to the formulation of local health programs. A subcommittee of the Medical Preparedness Committee of The Medical Society of New Jersey is now preparing an outline to guide local health committees in setting up their programs. This report awaits review by the State Council, and when approved will be distributed to all local Defense Councils to assist them in organizing their health and medical programs.

SELECTIVE SERVICE MEETING

As indicated on page 316 of this issue of the *Journal*, a meeting of the Preparedness Committee was held in Atlantic City on Tuesday evening, May 20, at which representatives of both the State and Federal Selective Service Headquarters met with some 300 physicians serving as medical examiners on draft boards or induction teams. This meeting was held at the suggestion of the New Jersey Selective Service System. Dr. Leonard Rowntree and Major Edgar Shattuck, Medical Director and Legal Adviser, respectively, of national Selective Service Headquarters, were present and discussed the problems presented by the doctors. The legal liability of draft board examiners was one of the chief topics of discussion. (See page 316, under "Tuesday Evening" for a summary of the meeting.) Complete minutes of this meeting are in preparation and will be distributed, on request, among members of the State Committee and examining boards.

TESTING FOR TUBERCULOSIS

New Jersey has taken a very progressive step in its new tuberculosis testing of school children law.

In most instances this test is being applied only in the high school grades.

With the Patch Test, the public objection to a hypodermic needle has been removed.

The technique is very simple; i. e., the part of the arm used is washed well with acetone or ether to remove all fat particles. The Patch Test is then applied, being sure all parts of the patch contact the skin.

Instruct the patient to remove the patch in two days, and to appear for a reading on the second day after the patch has been removed.

For all those showing a positive reaction, a complete physical examination and chest x-ray is needed also, as a part of the examination.

Such yearly examinations will be mutually advantageous to patient and physician, and the cost is not burdensome to the public.

CHESTER R. BROWN, M.D.,
Chairman, Child Health Committee.

**1941 ANNUAL MEETING —
REGISTRATION**

County	Delegates	Members	
Atlantic	9	76	
Bergen	15	10	
Burlington	4	18	
Camden	10	42	
Cape May	4	6	
Cumberland	3	11	
Essex	56	96	
Gloucester	5	10	
Hudson	28	30	
Hunterdon	2	1	
Mercer	15	33	
Middlesex	8	14	
Monmouth	7	24	
Morris	9	14	
Ocean	3	6	
Passaic	14	14	
Salem	1	2	
Somerset	3	16	
Sussex .....	..	3	
Union	23	36	
Warren	2	7	
	<hr/>	<hr/>	Totals
	221	469	690
Visiting Physicians			57
			<hr/>
Total Physicians Registered			747
Woman's Auxiliary		240	
Exhibitors		122	
Visitors		278	
			<hr/>
			640
			<hr/>
Total Registration			1387

**NUMBER OF CHILDREN REPORTED RECEIVING FREE STATE BIOLOGICALS
SINCE JULY, 1940****DIPHTHERIA TOXOID**

County	Total to Mar. 31	Month of Apr.	Total to Apr. 30	Average per Month
Atlantic	7149	19	7168	716.8
Bergen	2113	224	2337	233.7
Burlington	409	141	550	55.
Camden	1204	29	1233	123.3
Cape May	23	13	36	3.6
Cumberland	75	16	91	9.1
Essex	6455	564	7019	701.9
Gloucester	113	133	246	24.6
Hudson	3393	764	4157	415.7
Hunterdon	106	16	122	12.2
Mercer	1438	936	2374	237.4
Middlesex	611	4	615	61.5
Monmouth	972	16	988	98.8
Morris	423	37	460	46.
Ocean	177	0	177	17.7
Passaic	3516	251	3767	376.7
Salem	221	383	604	60.4
Somerset	253	8	261	26.1
Sussex	4	6	10	1.
Union	1379	98	1477	147.7
Warren	62	3	65	6.5
Totals	30096	3661	33757	3375.7

SMALLPOX VACCINE

County	Total to Mar. 31	Month of Apr.	Total to Apr. 30	Average per Month
Atlantic	671	9	680	68.
Bergen	1271	69	1340	134.
Burlington	270	3	273	27.3
Camden	1302	26	1328	132.8
Cape May	57	0	57	5.7
Cumberland	124	12	136	13.6
Essex	5536	413	5949	594.9
Gloucester	210	3	213	21.3
Hudson	2677	474	3151	315.1
Hunterdon	21	4	25	2.5
Mercer	986	44	1030	103.
Middlesex	861	6	867	86.7
Monmouth	362	2	364	36.4
Morris	512	32	544	54.4
Ocean	21	0	21	2.1
Passaic	2163	193	2356	235.6
Salem	237	13	250	25.
Somerset	146	7	153	15.3
Sussex	21	0	21	2.1
Union	1153	59	1212	121.2
Warren	191	2	193	19.3
Totals	18792	1371	20163	2016.3

The One Hundred and Sixty-fifth Legislature of the State of New Jersey

ASSEMBLY CHAMBER
STATE HOUSE, TRENTON, N. J.

ASSEMBLY CONCURRENT RESOLUTION

By Mr. Hargrave, of Essex County

Introduced and Adopted by the House of Assembly May 19, 1941, and
Concurred in by the Senate May 19, 1941

WHEREAS, The Medical Society of New Jersey, the oldest medical society in the United States, having been founded ten years before the independence of our country, is celebrating in annual convention at Atlantic City, May 20th to the 22nd, the 175th anniversary of its organization; and

WHEREAS, The Medical Society of New Jersey and its members have rendered over this long period of years signal service to the public welfare of this State; therefore

Be It Resolved, That the House of Assembly of the New Jersey State Legislature (the Senate concurring), extends to the Medical Society of New Jersey its congratulations upon its 175th anniversary and its best wishes for the continued success and service of this organization; and

Be It Further Resolved, That a copy of this resolution, signed by the President of the Senate and the Speaker of the House, and attested by the Secretary of the Senate and the Clerk of the House, respectively, be forwarded to Doctor Watson B. Morris, President of the Medical Society of New Jersey, at Haddon Hall, Atlantic City, New Jersey.

Rose P. Mc Clare
Speaker of the House of Assembly.

Attest:

Paul Williams
Clerk of the House of Assembly.

Frank B. Rowland
President of the Senate.

Attest:

John H. Smith
Secretary of the Senate.

I hereby certify that this is a true and official copy of a resolution introduced and adopted on Monday, May 19, 1941.

Paul Williams
Clerk of the House of Assembly.

OBITUARIES

DR. JOHN CHARLES MCCOY

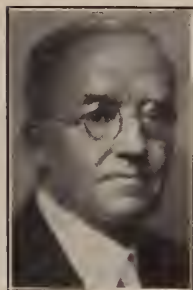
John Charles McCoy, Lieutenant-Colonel in the Medical Reserve Corps of the United States Army, and Consulting Surgeon to the Paterson and Dover General Hospitals, died at the New York Medical Center, April 16, 1941, at the age of 74. Dr. McCoy, a native of New York City, was graduated from the College of Physicians and Surgeons in 1891. He joined The Medical Society of New Jersey the following year, his sponsor being Dr. Elias J. Marsh, Sr., who was then the President of The Medical Society of New Jersey. Dr. McCoy was one of the founders of the American Board of Surgery.

Dr. McCoy was awarded the Distinguished Service Medal of the War Department on November

11, 1919. He was cited for "exceptionally meritorious and distinguished service, for distinguished success in caring for a large number of wounded from the Battle of the Marne". His services to the A. E. F. were characterized by the War Department as "invaluable".

DR. EDWARD IRVING IVES

Edward Irving Ives, M.D., died at the Mountain-side Hospital in Montclair on May 21, 1941. A graduate of New York University Medical School, class of 1908, Dr. Ives settled in Little Falls in 1912. He promptly became a member of the Passaic County Medical Society, and remained a loyal and active member until the date of his untimely death. Dr. Ives was also active in the Associated Physicians of Montclair and Vicinity. One of the leading practitioners of Little Falls, his death at the age of 55 came as a shock to his hundreds of friends, patients and colleagues.



DECEASED PHYSICIANS — NEW JERSEY

Name	Age	Date of Death	Place of Death	Residence	Cause of Death
Arthur W. Belting	62	March 24, 1941	Trenton	Same	Coronary thrombosis.
Henry H. Brevoot	65	March 18, 1941	Lodi	Same	Cerebral embolism.
John T. Gillson	79	March 23, 1941	Paterson	Same	Carcinoma of liver.
Edward F. Kopetschny	78	March 23, 1941	Jersey City	Same	Coronary thrombosis.
William O. Quinby	64	March 24, 1941	East Orange	Same	Coronary occlusion.
Valentine Ruch	65	March 30, 1941	Alpine	Englewood	Acute coronary occlusion.
Alfred C. Wallin	70	March 10, 1941	Matawan	Same	Hemorrhage of brain.
F. Rudd McDonald	52	April 2, 1941	Jersey City	Same	Coronary occlusion.
Alexander E. McLarty	52	April 22, 1941	Jersey City	Bayonne	Cerebral arterio sclerosis.
Ritchie C. Ovens	62	April 11, 1941	Jersey City	Same	Cerebral hemorrhage.
Frederick C. Robertson	69	April 6, 1941	Belmar	Jersey City	Coronary occlusion.
Louis Ruch	61	April 26, 1941	Englewood	Same	Cerebral hemorrhage.
Alfred W. Ward	62	Feb. 8, 1941	Demarest	Same	Coronary thrombosis.
Herbert Willis	59	April 9, 1941	Barnegat	Beach Haven	Arteriosclerosis.
Dirkran M. Yazujian	61	April 27, 1941	Trenton	Trenton	Carcinoma of sigmoid.

COMMISSIONS IN THE NAVAL RESERVE

The Surgeon General of the Navy has recently announced that there are nearly one thousand vacancies in the Medical Corps of the Naval Reserve. Most of the vacancies are in the Volunteer General Service group, which is made up of physicians who are under thirty-five years of age at the time of being commissioned. Internes and residents, as well as practicing physicians, are eligible.

There are also vacancies in the Volunteer Special Service group, made up of qualified specialists, who may be accepted up to fifty years of age. There is need, in particular, for additional radiologists and

psychiatrists. When mobilized, specialists are assigned to Hospital Units for work in their specialty.

Physicians who enroll in the Naval Reserve obligate themselves to serve during a war or national emergency.

For further information apply to the office of the District Medical Officer, Third Naval District, Federal Office Building, 90 Church Street, New York, N. Y. If a resident of Pennsylvania or South New Jersey, apply to the District Medical Officer, Fourth Naval District, Navy Yard, Philadelphia, Pa.

COUNTY SOCIETY REPORTS

ATLANTIC COUNTY

Charles Hyman, M.D., Reporter

The regular monthly meeting of the *Atlantic County Medical Society* was held at the Hotel Ambassador April 18, 1941. The meeting was called to order by the President, Dr. V. E. Johnson, at 9 p. m.

SCIENTIFIC

Dr. Walter I. Lillie, Professor of Ophthalmology at Temple University, spoke on "Fundal Changes in Arterial Hypertension". Dr. Lillie expressed the need of proper evaluation of the fields as important in the prognosis. The study and interpretation of the pathology in the vessels is more important than the amount of exudate and hemorrhage. Marked changes if due to spasm are better prognostically than minimal changes due to organic change. The paper was discussed by Drs. Harle, Schwarzkopf, Scanlon and Barbash.

MEDICAL PREPAREDNESS

Dr. Kilduffe reported his correspondence with Selective Service officials and felt that the military organization has no intent of keeping drafted physicians without commissions.

TELEPHONE LISTING OF OSTEOPATHS

Dr. Kilduffe reported for the Telephone Committee and stated that no progress has been made in the effort to separate our listing from the osteopaths. The matter is now in the hands of the Board of Trustees.

MEDICAL SERVICE PLAN

Dr. Scanlon, for the Insurance Committee, reported that sixty-five members had signed up for the Medical Service Plan.

POST-GRADUATE

Dr. Durham reported the successful conclusion of the annual post-graduate course.

ANNUAL OUTING

Dr. Westney announced the annual outing at Dox Folly for June 11.

MEDICAL PRACTICE

Dr. Hyman, Vice-Chairman of the enlarged Medical Practice Committee, announced that members of this committee are sitting with the draft board physicians and acquainting the rejectees with the reasons for their rejections. They are advised to report to their own respective physicians for treatment. Forms have been printed to give to these men and copies are sent to their doctors. One copy is kept for permanent record of the Society.

BURLINGTON COUNTY

T. Bruce Dickson, M.D., Reporter

The regular meeting of the *Burlington County Medical Society* was held on March 13, 1941, at the Moorestown Field Club, with thirty-seven members present.

FEE SCHEDULES

At the request of the authorities of Fort Dix the County Society composed a schedule of recommended fees for professional services to cover emergency work among civilians who are employed there.

SCIENTIFIC

Mr. Richard A. Spencer, Claim Supervisor of the Liberty Mutual Insurance Company of Philadelphia, talked on "The Malingerer, the Surgeon and the Insurance Carrier". Mr. Spencer gave some abstracts from case reports of claimants with alleged low back complaints and illustrated the reports with moving pictures taken of the claimants without their knowledge by Mr. J. O'Rourke, Jr., special investigator for the insurance company. Following this demonstration, Dr. William Bates, of Philadelphia, gave a number of his experiences with such cases. A profitable discussion followed in which Dr. Joseph Londrigan, of Hudson County, took an active part.

The April meeting of the *Burlington County Medical Society* was held on April 10, 1941, at Moorestown with forty-eight members present.

SCIENTIFIC

Dr. I. S. Ravdin, Professor of Surgery, University of Pennsylvania, spoke on "The Vagaries of Hyperthyroidism". His interesting talk was followed by an enthusiastic discussion in which most of the Society's members took part.

The regular meeting of the *Burlington County Medical Society* was held at the Medford Lakes Lodge on May 8, 1941 with thirty members present.

The members of the Woman's Auxiliary to the County Society were also present.

Dr. George Tracy, the retiring President, in his farewell address described the progress made by the County Society in the past year.

After his address, Dr. Tracy introduced the new President, Dr. Dean H. LeFavor, who made a short acceptance speech.

OFFICERS

The officers of the County Society for the coming year are:

President, Dr. Dean H. LeFavor
Vice-President, Dr. Harry B. Mark

President-Elect, Dr. Parry M. Scott
Secretary, Dr. E. Warren Rodman
Treasurer, Dr. E. Vernon Davis

After the business meeting refreshments were served.

ENTERTAINMENT

Dr. Tracy then introduced Mr. Roy Howell, of Atlantic City, an astrologer. For the next forty-five minutes Mr. Howell had his audience in gales of laughter as he singled out various members and described their characteristics according to the signs of the Zodiac. It was most interesting and no mistakes were made by Mr. Howell.

CAMDEN COUNTY

Harold D. Barnshaw, M.D., Reporter

The regular meeting of the *Camden County Medical Society* was held in the City Dispensary Building on March 4, 1941, at 9 p.m.

MEMBERSHIP

Drs. Stetser and Lipsitz, recently elected members, took the oath of membership and were introduced to the Society.

Dr. Robert Traganza was elected to active membership.

SCIENTIFIC

Dr. Edward A. Schuman gave an interesting talk entitled "Leaves from an Obstetrician's Notebook".

POST-GRADUATE

Dr. D. F. Bentley, Jr., announced the program of the Post-Graduate Committee.

The regular meeting of the *Camden County Medical Society* was held at the Cooper Hospital on April 1, 1941.

OFFICIAL VISIT

Dr. R. Gamon introduced Dr. Morris, President of The Medical Society of New Jersey, who announced the program for the Annual Meeting.

SCIENTIFIC

Dr. D. F. Bentley, Jr., presented "Reduplication of Ureter", with discussion by Dr. Wright.

"Lessons from Cancer Cases in the Tumor Clinic" was presented by Dr. H. P. Shipps, with discussion by many of the members.

Dr. T. McGlade presented a paper on "Laryngeal Complications of Abdominal Operations".

Dr. Del Duca concluded the program with "A Wilms Tumor Case Report".

HONORARY MEMBERSHIP

Dr. Leslie Lyon, of Magnolia, was elected to Honorary Membership.

ANNUAL OUTING

Dr. J. Shipman was appointed Chairman of the Committee for the Annual Outing. Drs. Shafer and Glover were appointed assistants.

Following the meeting refreshments were served by the hospital.

CAPE MAY COUNTY

Clarence W. Way, M.D., Reporter

ANNUAL MEETING

On Tuesday, May 13, the *Cape May County Medical Society* celebrated its annual meeting in Ocean City with a shore dinner at Simm's Restaurant, at which the members and their wives welcomed President Morris; Dr. Wilkes, Executive Officer; Dr. Quigley, Past-President of the State Society; Dr. Ulmer, Judicial Councilor for the Fifth District; Dr. Sewall, of Cumberland County; and Dr. Diverty, President of Gloucester County Medical Society.

A beautiful covered silver vegetable dish, suitably inscribed to show their appreciation and admiration of Dr. Aldrich Crowe, their retiring President and Secretary of the Board of Trustees of the State Society, was presented by the Cape May County Society. Dr. Wilkes was asked to make the presentation on behalf of the Society. Dr. Crowe acknowledged the gift as further evidence of the support and confidence always given him by the members of the Society, and thanked the members for their kindness.

Guests of honor at the meeting were Mr. and Mrs. Burdette Tomlin, Ocean City. Mr. Tomlin on May 6th had placed in escrow in a Cape May Court House bank the sum of \$25,000 to be used for the construction of a Cape May County Hospital, provided that the public can raise the necessary balance. Support for the hospital project was vigorously pledged by the County Medical Society and its Auxiliary.

Drs. Quigley, Wilkes, Diverty and Sewall were voted in as honorary members of the Society,—an honor which each acknowledged with thanks and appreciation.

Mrs. McDonald, of Paterson, President of the Woman's Auxiliary, spoke to urge the wives of the members to establish an Auxiliary in Cape May County, and Dr. Hughes, the incoming President, promised to enlist the support of the members of the Society for the Auxiliary. Dr. Way, as Secretary, presented Mrs. McDonald with an orchid corsage.

The new officers were elected unanimously as follows:

President, Samuel B. Hughes, Wildwood
Vice-President, George Brooks, Cape May Court House
Secretary and Reporter, C. W. Way, Sea Isle City
Treasurer, Warren D. Robbins, Cape May.

CUMBERLAND COUNTY

Mary Bacon, M.D., Reporter

The regular meeting of the *Cumberland County Medical Society* was held on April 8, 1941, in Cumberland Hotel, Bridgeton, with the President, Dr. Charles Butcher, presiding.

SCIENTIFIC

Dr. Catherine Macfarlane, Professor of Gynecology at the Woman's Medical College of Pennsylvania, addressed the Society on "Progress in Cancer Prevention Research". Dr. Macfarlane explained her plan, in the development of which twelve hundred healthy women are being examined semi-annually over a five-year period by Dr. Macfarlane and her assistants, in order to detect very early evidence of cancer, thereby increasing their knowledge of diagnosis and effectual treatment in this disease. This work will be of inestimable value to physicians interested in the treatment of malignancy.

ELECTION OF OFFICERS

The following officers were elected:

President, Helen E. Weithaase, Vineland
Vice-President, Sherman Garrison, Cedarville
Treasurer, H. H. Wilson, Bridgeton
Secretary, F. M. Ramsey, Millville
Reporter, E. C. Lyon, Bridgeton
Executive Committee: H. G. Miller, Millville;
Dare Woodruff, Vineland; Mary Bacon, Bridgeton.

M. F. Sewall was reappointed Censor, and H. G. Miller was appointed Delegate to the State Convention, with Mary Bacon as Alternate.

McCLAVE ACT

The McClave Act (Uniform Medical Practice) is strongly endorsed by the Society, preserving as it does the right of qualified physicians to the undisturbed practice of medicine.

This legislation bans fraudulent advertising and raises educational requirements for cultists.

Public attention is called to the fact that the McClave Act bulwarks the community against frauds and against fractionally educated healers.

POST-GRADUATE

Dr. Charles Sharp announced the beginning of a Rutgers Extension Refresher Course for Cumberland and Salem County physicians, beginning April 22.

Dinner was served in Cumberland Hotel dining room after the scientific session.

The June meeting of the Society will be held at Ivy Manor.

ESSEX COUNTY

Paul H. Hosp, M.D., Reporter

The regular monthly meeting of the *Essex County Medical Society* was held at the Academy of Medicine in Newark on Thursday evening, April 10, 1941. The President, Dr. Harry Comando, called the meeting to order at nine o'clock.

SCIENTIFIC

The speaker of the evening was Dr. Francis Carter Wood, Professor of Cancer Research, Columbia University. He spoke on the subject "Improvements in Diagnosis and Treatment of Lymph Node Disease". Lantern slides illustrated his talk.

He stated that with suitable x-ray application we are now beginning to cure those cases which before this time were considered incurable. Properly figured out dosage and application to those cases in which the cells are radio-sensitive causes the cure. Why some are sensitive and others not we can not explain.

The meeting was well attended and appreciated by those present.

COUNCIL MEETING

On Wednesday evening, March 26th, the Council of the Society entertained the Legislators of Essex County at the Down Town Club. This was the second time in as many years that this friendly get-together has taken place.

LEGISLATION

Dr. Harry Comando, President of the Society, made the opening remarks of welcome. He then turned the chairmanship of the gathering over to Dr. Frank Bien, the Chairman of our Legislative Committee. Dr. Bien spoke on several of the bills pending in the Legislature and gave the medical viewpoints on the same. The bills were discussed by several of those present and a better understanding was the result of the meeting.

Among those present were Senator Homer Zink, Assembly Members Sandford, Cavicchia, Mahr, Orbin and Wegrocki; Dr. Morris, President of The Medical Society of New Jersey; Dr. Alexander of Bergen and Dr. Quigley of Hudson County.

GLOUCESTER COUNTY

C. A. Bowersox, M.D., Reporter

The regular meeting of the *Gloucester County Medical Society* was held at the Woodbury Country Club on April 17th. Dr. Diverty, President of the Society, presided.

PUBLIC RELATIONS

Dr. Collins, of Glassboro, reported that the committee had furnished four speakers throughout the county during the past month.

MEDICAL PREPAREDNESS

Dr. William Pedrick made the plea that all members who have not filled in their A. M. A. questionnaire do so as soon as possible.

COMMITTEES APPOINTED

Dr. Henry Diverty appointed the following Auditing Committee:

Drs. C. A. Bowersox and Harry Nelson.

To the Advisory Committee on Medical Administration he appointed Drs. Joseph Hughes, Fred Faux and Horace Fooder.

SCIENTIFIC

Dr. W. D. Stroud, of Philadelphia, gave the address of the evening on "The Clinical Side of Heart Disease". He divided his remarks into the following four classifications:

1. *Rheumatic heart disease.*

He stated that very little is being done by the present public health committees to prevent and study rheumatic fever. For ideal treatment the child should be placed in a hospital until the acute stage subsides. For further treatment, the convalescent should be placed in a home to be educated and properly treated. Sulfanilamide is of great benefit in the later stages of rheumatic heart disease, but it is definitely contraindicated in the early acute stage. Ultraviolet light is now being used in various hospitals to decrease the amount of bacteria present. Sulfanilamide should be given in 20 to 30-grain doses a day.

2. *Digitalis Therapy.* Digitalis acts by:

- a. Slowing the heart rate.
- a. Increasing the tone of the cardiac muscle.
- c. Increasing ventricular systole.

Dr. Stroud advised the use of the powder leaf digitalis instead of the indefinite dosage by drops of the tincture. One-half to two grains a day of the powdered leaf is sufficient for a continuous treatment. This dose can be given once during the day.

3. *Coronary Disease.* The doctor should in no way be pessimistic concerning the prognosis of coronary disease. With moderate care and limited exercise, these patients might survive many years. It is advisable never to tell the patient that he has angina pectoris. It has often been noted that gall-bladder disease and gastric ulcers produce coronary symptoms, particularly where coronary disease is present. It has been found that the sub-sternal pain of coronary pathology is greatly benefited by the removal of the gall-bladder.

4. *Treatment of Angina.*

- a. Reassure the patient.
- b. Reduce daily routine.
- c. Sedation.
- d. Lower the basal metabolism.
- e. Use of nitro-glycerine only at the time of sub-sternal pain.
- f. Aminophyllin.

The discussion was opened by Dr. Ralph Hollinshead, of Westville. After this, Dr. Stroud presented two most interesting moving pictures on the electrocardiogram and its significance in relation to the heart action.

MAY MEETING

The monthly meeting of the *Gloucester County Medical Society* was held at the Woodbury Country Club on May 15, 1941, with the President, Dr. Henry B. Diverty, presiding.

CASE REPORTS

Dr. Thomas L. Sooy of Pitman, New Jersey, presented two interesting cases of multiple sclerosis with mental complications.

TREASURER'S REPORT

The Treasurer, Dr. Don Weems, gave his annual report, which showed that the Society is in very good financial status. The Auditing Committee appointed by the President approved the report as given.

NOMINATING COMMITTEE

The nominations for the officers of the Society for the coming year were given by Dr. Chester I. Ulmer, Secretary.

SCIENTIFIC

Dr. Franklin Buzby gave the talk of the evening on "Fractures of the Hip". He stated that great advance has been made in the past few years in the treatment of fractures of the hip. Some time ago non-union occurred in 75 per cent of the cases but since Dr. Whitman brought forth reduction associated with plaster casts and internal rotation in 1925, results have improved greatly. The use of the Smith-Peterson stainless steel pin in the hip has given even better results. Non-union occurs from improper blood supply to the hip and improper reduction. A reduction of 75 per cent is all that is required in the treatment. X-ray examination of the hip is very important. Union should occur in six months if the reduction is satisfactory. The mortality at the present time in all hospitals is approximately 10 per cent of all fractures of the hip.

HUDSON COUNTY

John N. Connell, M.D., Reporter

The regular meeting of the *Hudson County Medical Society* was held on Tuesday, April 1, 1941, at the Masonic Club, Jersey City.

The meeting was called to order at 9:30 p.m. by the President, Dr. G. Ginsberg.

SULFATHIAZOLE TABLETS

Dr. T. McG. Brennock reported that the Police Department requested that every stock container of sulfathiazole tablets 0.5 gm., bearing the label of the Winthrop Chemical Company, be examined immediately. Look for the Control Numbers M. P. 029 and M. P. 118. Do not use or dispose of any of these tablets. If you have a bottle of these tablets bearing the above numbers, notify the State Board of Pharmacy, Trenton, N. J.

MEMBERSHIP

Three candidates were proposed for membership. Two new members were elected:

Dr. Archie W. Johnson, Jersey City
Dr. Alex. S. Horowitz, Jersey City

ELECTIONS

The following Nominating Committee to serve in 1942 was elected:

J. L. Evans	C. J. Larkey
J. A. Botti	E. J. Daly
W. T. Callery	

Dr. James F. Norton was elected to fill the unexpired term (1943) of the late Dr. George B. Spath.

SCIENTIFIC

Dr. Hugo Roesler, Cardiologist, Department of Medicine, Temple University School of Medicine, spoke on the subject "Aspects of Circulatory Disturbances".

- a. Venous pulse.
- b. Dizziness and fainting.
- c. The endocrines.

The paper was discussed by Drs. Jaffin, White, Pearlstein, Barbarito and Nyboer, Research Associate in Electrocardiography of the Post-Graduate Hospital, New York.

REFUND OF DUES

The question of dues being refunded to doctors called to service was discussed and a communication from Dr. Harry R. North, Chairman of the State Society Finance and Budget Committee, was read.

Dr. J. F. Norton moved that we communicate with the Treasurer and the Chairman of the Finance and Budget Committee of the State Society, requesting them to remove the names of Drs. DeFusco and Angelo and inform them that two other names would be forwarded in their place, and that the dues will be refunded to Drs. DeFusco and Angelo.

The meeting was adjourned at 11:30 p. m.

MIDDLESEX COUNTY

Cyril S. Hutner, M.D., Reporter

The April meeting of the *Middlesex County Medical Society* was held at the Roosevelt Hospital, Metuchen, on Wednesday, April 16, 1941. It was called to order by Dr. R. J. Faulkingham, President.

SCIENTIFIC

Dr. Frank C. Henry, Jr., introduced Dr. Nelson W. Cornell, Associate Professor of Surgery at Cornell, who spoke on "Fixation of Fractures of the Femoral Neck by the Moore Nail Method". It was very favorably received and extremely instructive.

MEMBERSHIP

The following were elected to associate membership:

Dr. Marie Idelcowitz, South River, transfer from Essex County Medical Society
Dr. Lester A. Barnett, Milltown
Dr. S. C. Lavine, New Brunswick, transfer from Mercer County Medical Society.

OFFICIAL VISIT

Dr. Watson B. Morris, President of the State Medical Society, was then introduced. He spoke a few words about the details of the Annual Meeting of The Medical Society of New Jersey at Atlantic City in May.

MEDICAL PREPAREDNESS

Dr. Rowland reported that the Committee on Medical Preparedness was holding meetings and attempting to determine the minimum number of men necessary for care of the civilian population in case of a national emergency.

COMMUNICATIONS

1. From the State Society—Middlesex County Medical Society has a paid-up membership of 153 and is therefore entitled to ten delegates and ten alternates to the Nominating Committee. Only nine have been appointed.

Dr. J. F. McGovern was elected as the tenth Delegate and Dr. Frank C. Henry Jr., as his Alternate.

2. From Middlesex County Tuberculosis and Health League—Refresher courses available this Spring—fee \$5.00.

3. From the Woman's Auxiliary—The Art, Hobby and History Committee asks for exhibits for the Annual Meeting in May.

4. There is a Post-Graduate Course in Venereal Diseases presented by the Division of Venereal Disease Control, New Jersey State Department of Health.—Approved and recommended by the Venereal Disease Committee, Medical Society of New Jersey. No fee.

5. Walker-Gordon invitation to the Society to visit their farm. June 4th was date acceptable to the Society.

After the meeting adjourned refreshments were served in the cafeteria.

MORRIS COUNTY

F. Clyde Bowers, M.D., Reporter

The regular April meeting of the *Morris County Medical Society* was held on the evening of April 17th at the LaSalle Restaurant in Dover.

HERCULES DISASTER

Papers were presented by Dr. Plume, Dr. Costello and Dr. Baker, which purported to show the highlights of the Hercules disaster, the type and treatment of fractures and the treatment of abdominal and other injuries. Aside from the actual treatment of the cases, much was learned as to the handling of such disasters which might occur in the future. First of all, it was shown that it is necessary to have a definite plan for handling such accidents which will include the full cooperation of the Medical Society, hospitals, the Red Cross and the laymen. Many mistakes were made in the handling of these cases due to the lack of such organization, but in spite of this the results of treatment were remarkably good. It was pointed out that in the treatment of fractures in particular, there should

be splinting at the scene of accident, proper transportation, a survey of the cases to show which should be institutionalized, and which should be immediately operated upon. There should also be pre-reduction x-rays taken, which it was impossible to do in this particular catastrophe because of the lack of organization. In view of the difficulties encountered, the men in charge of the medical and surgical aspects of the disaster did very well as evidenced by the fact that there were no cases of tetanus, gas bacillus infection of infected wounds or compound fractures. Full credit is due those people who were confronted with the task of treating these patients.

A discussion of the papers was led by Dr. Robert Kennedy, Chairman of the Committee on Fractures of the American College of Surgeons. He was followed by Dr. Elmer Weigel, Chairman of the Committee on Fractures of the State Society. Further comments were given by Dr. McGee, Head Physician of Hercules Powder Company, and Dr. LeRoy Wilkes, Executive Officer of the State Society. All of these men were high in their praise of the surgeons who were responsible for handling the surgical conditions incident to this disaster, and it was the opinion of all those present that a better job could not have been done under such circumstances. However, it is hoped that in the future we shall have a well-outlined plan and a complete organization for handling a similar catastrophe in this county.

The meeting adjourned and supper was served.

OCEAN COUNTY

By Raymond A. Taylor, M.D., Reporter

The *Ocean County Medical Society* held its regular monthly meeting on the evening of May 14th at the Sunset Cabin in Lakewood, New Jersey

ELECTION OF OFFICERS

The following officers were elected:

President, Harry S. Ivory, Point Pleasant
Vice-President, Carl Menge, Toms River
Secretary, Robert Carmona, Tuckerton
Reporter, Raymond A. Taylor, Lakewood
Treasurer, LeRoy Falkinburg, Forked River

OCEAN COUNTY BLOOD TRANSFUSION FUND

Following this the election of Trustees and Officers of the Blood Transfusion Fund ensued. The Ocean County Blood Transfusion Fund is a non-profit-making organization sponsored by the Woman's Auxiliary to the Ocean County Medical Society. It is for the sole purpose of making blood available to any one requiring it regardless of sex, age, creed or financial status. All members of the Medical Society and its Auxiliary are members. Trustees elected from these groups were: Dr. William E. Dodd, Dr. Robert Buermann, Dr. Abraham Goldstein, Dr. Bruce Hendriksen and Dr. Raymond A. Taylor. Mrs. E. M. Sickel and Mrs. Raymond Taylor were elected as members of the Auxiliary. Also Mr. Osborne Havens and Mr. David Schulman

were elected as lay members. Officers elected were Dr. Raymond A. Taylor, President; Dr. Robert Buermann, Vice-President; Mrs. E. M. Sickel, Secretary; Mr. Osborne Havens, Treasurer.

This organization has done considerable work. Over fifty transfusions have been given from its members in the past year and the finances are handled in such a manner that all donors are paid a small amount from this Fund, and the pay patients, who receive the blood, donate into the Fund so that the Fund receives the pay from the patient, which is then distributed among the donors at a rate specified by the Trustees.

SCIENTIFIC

Following this a very excellent program was presented by Dr. Joseph E. Raycroft, Chairman of Mental Hygiene Committee of the State of New Jersey; Dr. J. Berkley Gordon, Medical Director of Marlboro State Hospital and the Marlboro Hospital Staff. This consisted of three plays portraying various forms of mental disease. On conclusion of this program a vote of thanks and appreciation was extended to the participants for their excellent work.

PASSAIC COUNTY

Irving Okin, M.D., Reporter

The regular monthly meeting of the *Passaic County Medical Society* was held on Thursday evening, April 17, 1941, at Hope Dell, Preakness, the County Welfare Home. The President, Dr. Frank W. Ash, presided.

MEMBERSHIP

The following new members were elected:

Active Membership:

Harry H. Capell, M.D., Paterson
William Grosfeld, M.D., Paterson

Associate Membership:

George Asten, M.D., Haledon
Theodore Pollock, M.D., Clifton

BRITISH RELIEF

Dr. William Spickers announced that plans were being formulated to obtain supplies and samples of drugs to be sent for British relief. The Society moved that this be endorsed.

SCIENTIFIC

Dr. Leo Becker introduced the speaker of the evening, Dr. Emil Novak, Associate in Gynecology at Johns Hopkins Medical School. His topic was "Cancer as It Concerns the Gynecologist". Dr. Novak gave a very fine talk and emphasized the early diagnosis of cancer. He said that it was up to each doctor to educate his patients along cancer lines, and he felt that the same publicity and education was necessary as was carried on in tuberculosis. It was more difficult, he said, to make a diagnosis in the early stages, but at that time the patient could be cured. He described the various lesions of the cervix in cancer and spoke of the types of treatment: radium, x-ray, and operation.

He also talked on the estrogens. Questions were asked by Drs. Shulman, Spickers and Dingman.

Dr. Ash announced with sorrow the death that morning of Dr. John C. McCoy.

Following the meeting, a collation was served, and a very large attendance enjoyed an entertaining evening as the guests of Hope Dell.

The *Passaic County Medical Society* celebrated its annual meeting on May 8, 1941, with a dinner in honor of the following members who have been in the active practice of medicine for fifty years or more:

James W. Atkinson	William Neer
Victor E. Bullen	Charles Scribner
William Earle Chase	Richard Stinson
David Crounse	Percy N. Terhune
William Flitcroft	Francis H. Todd
Byran C. Magennis	George Edward Tuers
Andrew F. McBride	

It was an enjoyable and fitting occasion for a well-merited recognition of the faithfulness and steadfast purpose of these men.

An excellent dinner was enjoyed by the large number of members and guests present.

President Morris of the State Society, Dr. Wilkes, Executive Officer, and Dr. Scott, Medical Director of Medical Service Administration, were among the guests.

Dr. Jacques Romano, of New York, the guest speaker, entertained and mystified everyone in his own inimitable manner.

Dr. Maclay presented a eulogy of Dr. John C. McCoy, which was well received.

SALEM COUNTY

L. C. Hummel, M.D., Reporter

The regular reorganization meeting of the *Salem County Medical Society* was held April 18th at the Salem Tea Room, Salem, N. J.

ELECTION OF OFFICERS

The following officers were elected for the coming year:

President, Dr. E. E. Evans
 Vice-President, Dr. W. D. Norwood
 Secretary and Treasurer, Dr. J. S. Dunn
 Reporter, Dr. L. C. Hummel
 Delegate to the State Society, Dr. C. L. Flemming
 Alternate, Dr. C. W. Thomas

Delegates to County Societies, to remain the same as previous year

Censors: Drs. F. L. Perry, H. F. Suter, L. C. Hummel

SHAD DINNER

A report from the Entertainment Committee gave the date for the shad dinner as May 28th, to be held at the Salem Country Club. A motion was carried to set the price of the dinner at one dollar and fifty cents, payable on acceptance of the invitation.

SCIENTIFIC

The Society was addressed by Dr. Margaret Sutley, of Philadelphia, Pa. Her topic was "Medical Experiences in Japan". She spoke of the many difficulties necessary to overcome in mastering the language and customs in order to understand and treat patients. The hospitals were described as shocking with their overcrowding, poor sanitation and general management. Families of the patients prepare the meals over charcoal burners at the foot of the bed, thus eliminating any need for a diet kitchen. No provision is made for segregating patients,—all types of cases, infections, surgical, obstetric, etc., are crowded into the same ward in adjoining beds. Dr. Sutley said typhoid and parasitic diseases were particularly prevalent due to the use of human excreta for fertilization. She also mentioned the high infant mortality but suggested it might not be too unfortunate as the Japanese are an extremely prolific race and overcrowding would be worse than it is already. Her talk was greatly enjoyed by all, and general discussion continued over the dinner table following the meeting.

SUMMIT MEDICAL SOCIETY

E. H. Macpherson, M.D., Secretary

The regular monthly meeting of the *Summit Medical Society* was held at the Nurses' Home of Overlook Hospital on Tuesday evening, April 29th. Dr. Steuart, the Vice-President, presided. There were eighteen members and ten guests present.

SCIENTIFIC

The speaker of the evening was Dr. Harold J. Stewart, Assistant Professor of Medicine of Cornell Medical School, who spoke on "Chronic Constrictive Pericarditis, Medical and Surgical Aspects". This talk was illustrated with slides.

Following the meeting a collation was served.

THE NEW JERSEY GASTROENTEROLOGICAL SOCIETY

The *New Jersey Gastroenterological Society*, under the presidency of Dr. Hyman I. Goldstein, Camden, met at the General Hospital, Elizabeth, N. J., April 7th, 1941.

Participants on the program were Drs. Harrison

R. Wesson, Montclair; Louis L. Perkel, Jersey City; Manfred Kraemer, Newark, and A. L. Reich, Newark, N. J.

The next meeting will be held at the Jersey City Medical Center, October 6th, 1941.

WOMAN'S AUXILIARY

THE AUXILIARY AT THE ANNUAL MEETING

By MRS. ASHER YAGUDA, Chairman, Press and Publicity

The Fourteenth Annual Meeting of the Auxiliary was held at Atlantic City May 20, 21 and 22. The sessions were interesting and well attended. All of the fifteen organized counties were represented.

On Tuesday, Mrs. R. J. McDonald, of Paterson, presided over a meeting of the Executive Board. Despite the fact that those members who drove to the meeting were delayed by the maneuvers of a large portion of the National Guard and 44th Division on their way to a "defense" of Atlantic City, business was satisfactorily transacted and the members adjourned for luncheon. At 3:00 p. m. over fifty of us participated in the rolling-chair ride given by the Medical Society for the Auxiliary. The sun was shining at the perfect angle for the boardwalk photographers. Next day, pictures of the rolling-chair cavalcade were exhibited in the lobby of the hotel and elicited many squeals of delight and groans of despair.

At the Wednesday business session, Mrs. R. J. McDonald introduced Dr. Henry Merle Mellon, of Atlantic City, who gave the invocation. This was followed by the address of welcome by Mrs. Anthony G. Merindino, President of the Atlantic County Auxiliary. The incoming President of the New Jersey Auxiliary, Mrs. Oswald R. Carlander, of Merchantville, gave the response. The memorial service for departed members was conducted by Mrs. James R. Hunter, of Westville. The reports of the officers, chairmen and county presidents were given and the meeting adjourned for the luncheon honoring Mrs. R. J. McDonald, retiring President. Dr. Watson B. Morris was

the principal speaker. Mrs. A. Haines Lippincott presented the Past President's Pin to Mrs. McDonald. The business session then continued and at this time the new slate of officers was read. Mrs. McDonald gave the gavel over to Mrs. Carlander and Mrs. Carlander introduced the new officers.

At 4:00 p. m. Mrs. Ily R. Beir was hostess at a tea in the Art and Hobby Exhibit room. This exhibit gets better and better each year, and to view it is to understand how Mrs. Beir has New Jersey occupying first place in this department of the National Auxiliary.

The banquet, starting at 7:30 p. m., in the capable hands of Dr. William J. Carrington as toastmaster, was a success from the opening sentence. An "Information Please" on the history of The Medical Society of New Jersey was entertaining, and the holders of high scores were given prizes of cartwheel silver dollars. The visiting celebrity, a Past President of the National Auxiliary, Mrs. Rogers N. Herbert, of Nashville, Tenn., was introduced. Mrs. R. J. McDonald and Mrs. Oswald R. Carlander were seated at the speakers' table and both welcomed the guests. The dinner was followed by a dance.

The new President, Mrs. Carlander, presided at a meeting of the new Executive Board on Thursday morning, when the policy for the coming year was determined.

Many thanks to Mrs. McDonald for the splendid work accomplished during her presidential year. We bid her a regretful farewell. Much luck and a successful regime to Mrs. Carlander!

THE AUXILIARY HISTORY

By MRS. JAMES HUNTER, Historian

The History of the Woman's Auxiliary from 1927-1940 was completed on time, forwarded to the parent society and received the public commendation of the National Historian, Mrs. John J. Ryan.

Her article in the Spring issue of the Bulletin deserves our interest. You will notice that she, too, had difficulty in receiving all reports and has asked the indulgence of the National.

Your Chairman felt that New Jersey's efforts deserved its rightful "place in the sun", and so she devoted much time to research work in order to present a conservative, readable, worthy history.

Her preparation revealed much had been done. We predict much more will be done, and it's hoped that we will mend our fences as we travel.

We are done with the years that were—
We are quits.
We are done with the dead
And the old;
They are mines worked out.
We delved in their pits,
We have saved their gold;
Now we turn to the future
For wine, for bread.
We have bidden the past adieu;
Life hands to the years ahead:
"Come on—We are ready for you."

We know we gather out of history a policy no less wise than eternal by the comparison and applications of others' mistakes. Remember that the office of history should be to prevent virtuous actions from being forgotten, and

so we here pay tribute to those women, who with understanding minds and willing hands are serving so gallantly.

In an effort to unify reports and as the result of the lessons learned in preparing the history, permanent instructions have been prepared and these we hope will find favor in each county. May we ask that attention be given these directions for organizing and keeping up "to the minute" history of the Auxiliary. The way "never to be late is to start on time".

May the next call from the National find us completely and satisfactorily on the job, bearing in mind that through the history and through that alone can we present a concrete picture of the work of the Woman's Auxiliary to The Medical Society of New Jersey.

EXECUTIVE BOARD MEETING

By MRS. BANKS BAKER, Recording Secretary

The regular meeting of the *Executive Board* of the Woman's Auxiliary to The Medical Society of New Jersey was held at the Essex House, Newark, on Monday, March 10th, at 11:00 a. m. The meeting was called to order by the President, Mrs. R. J. McDonald.

REPORTS

The Treasurer: Mrs. T. P. McConaghy reported a balance of \$858.10.

The President: Mrs. R. J. McDonald reported that she had visited Bergen and Hudson County Auxiliaries.

Arrangements: Mrs. J. Irving Fort, Chairman, reported that all plans have been made for the meeting and the luncheon, and thanked Mrs. Keller for her assistance.

Archives: Mrs. C. Chester Chianese, Chairman, reported that papers and documents have been filed, and called special attention to the "History of the First Twelve Years of the New Jersey Medical Auxiliary" which has been compiled by Mrs. Hunter, our Historian. This history will be on display at the exhibit this year.

Art, Hobby and Medical History: The Chairman, Mrs. Ily R. Bier, stated that the double objective of this committee is to assist in the attraction of the Annual Meeting by our exhibition, and to collect data on the Medical History of New Jersey; and urged every county president and sub-chairman of this committee to make every effort to assist.

Entertainment: Mrs. David B. Allman, Chairman, submitted the tentative program for the Annual Meeting.

Mrs. Fort called attention to the fact that the Federation is celebrating its Golden Jubilee at the same time as our meeting and suggested that reservations be made early.

Finance: Mrs. Chester I. Ulmer, the Chairman, requested that all bills be submitted to her by May 1.

Historian: Mrs. McDonald stated that Mrs. Hunter has a very fine letter to be sent out and requested that the counties cooperate in order that Mrs. Hunter may compile the history for this year.

Legislation: Mrs. A. W. Bickner, Chairman, called attention to the bills now pending and defined each briefly. Mrs. Bickner urged all members "to be one step ahead and know the answers" by reading the many articles that appear in the Journal and by inviting speakers on Medical Legislation to Auxiliary meetings.

Medical Preparedness: The Chairman, Mrs. A. M. Schultz, reported orally.

Mrs. Beir advised that she and her committee were collecting instruments and samples. These supplies are to be sent to Britain.

Press and Publicity: Mrs. Asher Yaguda, Chairman, reported that since January we have published in the Auxiliary pages of each issue of the Journal an article by a Committee Chairman of the State Board describing the work and purpose of her committee. Mrs. Yaguda also requested County Presidents to urge their Publicity Chairmen to have every item concerning the Auxiliary published in the newspapers of their counties.

Printing: Mrs. J. J. McGuire, Chairman,

reported concerning the stationery and cards for membership files.

Public Relations: Mrs. Don A. Epler, Chairman, asked that the questionnaire which she sent out be returned. Until these are received, Mrs. Epler cannot complete her report to the National.

Widows and Orphans: The Chairman, Mrs. W. D. Miningham, had no report. Mrs. McDonald urged all members to try to get some of the doctors to join this society, pointing out the advantages and low cost to the individual.

Credentials: Mrs. J. Howard Hornberger, Chairman, reported a total of forty-seven members and guests present.

Bulletin: Mrs. S. H. Jessurun, Chairman, reported sixteen subscriptions since the January meeting. Passaic County leads with a total of forty subscriptions.

COUNTY REPORTS

Reports were presented by the Presidents of the following Counties: Bergen, Burlington, Camden, Essex, Hudson, Middlesex, Ocean, Passaic and Union.

DELEGATES

The President reported that all delegates and alternates have been notified. Mrs. A. E. Jaffin was appointed to replace Mrs. Ulmer, who is unable to attend the meeting.

CORRESPONDENCE

A letter from the New Jersey Social Hygiene Association was read. A donation of ten dollars to this association was approved.

A letter from the Auxiliary to the Philadelphia County Medical Society was read and three delegates were appointed to attend the meeting—Mrs. Chester I. Ulmer, Mrs. Don A. Epler and Mrs. W. E. Dodd.

REVISIONS

Mrs. Epler moved that a copy of the revisions be printed in order that they may be inserted in the Constitution and By-Laws. Seconded by Mrs. Bickner and carried. Mrs. Dodd and Mrs. McGuire were appointed as a committee to take care of the printing of these revisions.

COUNTY AUXILIARIES

Atlantic County

Reported by Mrs. Matthew Molitch, Chairman,
Press and Publicity

The regular meeting of the *Woman's Auxiliary to the Atlantic County Medical Society* was held on Friday, April 18, 1941, with Mrs. Anthony G. Merendino presiding. There were nineteen members present.

Reports were received from the Co-chairman of Entertainment, Mrs. David Allman, and from the Legislative Chairman, Mrs. G. Ruffin Stamps.

The speaker for the evening was Mrs. Allan Rieck, Atlantic County Chairman of Art, Hobby and Medical History, who spoke on the method of compiling medical histories, and then gave a dissertation on "American Glass" with representative pieces from her own collection.

Bergen County

Reported by Mrs. J. Willis Demarest, Publicity
Chairman

The regular meeting of the *Woman's Auxiliary to the Bergen County Medical Society* was held Tuesday evening, April 8, 1941, at the Hackensack Hospital, with Mrs. Berke presiding. There were eighteen members present.

Reports were given by Mrs. Lester Netz, Treasurer; Mrs. A. F. Macauley, Recording Secretary; Mrs. S. Alexander, Legislative Chairman, and Mrs. Alvah Bickner, Public Relations Chairman.

The following officers were elected:

President-Elect, Mrs. Otto Hensle

First Vice-President, Mrs. P. Caruso

Second Vice-President, Mrs. Walter Mobrys

Treasurer, Mrs. Lester Netz

Secretary, Mrs. Lyman Brown

Director, Mrs. A. F. Macauley

Mrs. H. M. Meyer is the new President for the next two terms.

On May 6 the Auxiliary will hold a Public Meeting at the Hackensack Women's Club. The speaker will be Dr. Caspar Folroff and his subject will be "Rhythm and Teamwork in the Function of the Glands". Dr. Folroff was formerly associated with Johns Hopkins and Columbia University and is a most interesting speaker. The Auxiliary extends an invitation to anyone wishing to attend. Tea will be served after the lecture.

This summer the Auxiliary will send six underprivileged boys to Camp Oratam in Bear Mountain.

The last meeting of the year will be a luncheon on May 13 at 1 p. m. at the Swiss Chalet, Rochelle Park, N. J. At that time the annual reports will be read.

Camden County

Reported by Mrs. E. Reed Hirst, Publicity
Chairman

The Executive Board meeting of the *Woman's Auxiliary to the Camden County Medical Society* was held on Tuesday, April 1, at 10:30 a. m., at the home of the President, Mrs. Lawrence L. Glover, Haddonfield, N. J. There were nineteen members present.

Mrs. A. H. Lippincott reported that about \$200 has been realized through the efforts of the Auxiliary members for the Greek War Relief.

A special votes of thanks was given to Mrs. A. H. Lippincott for her fine and untiring work on cancer control.

Reports were received from the several chairmen and plans were completed for the Annual Meeting and Luncheon, to be held at Tavistock Country Club. The date was changed from May 8 to *Thursday, May 1*. Program for the day will include a dramatic reading by Mrs. A. H. Lippincott. Mrs. Claude Campbell, violinist and singer, will be guest artist with Mrs. Robert Moran, piano accompanist.

Mrs. William F. Shafer was appointed and elected as Director for unexpired (three-year) term of Mrs. Max L. Weimann, who resigned as Director.

Mrs. Glover announced that the Annual Health Institute, sponsored by the Auxiliary to the Philadelphia County Medical Society, would be held on Tuesday, April 8. Three delegates were chosen by the Camden County Auxiliary to attend this meeting.

Following the meeting, luncheon was served.

Essex County

Reported by Mrs. Frank S. Forte, Chairman of Publicity

The *Woman's Auxiliary to the Essex County Medical Society* held its regular monthly meeting on Monday, March 24th, at 2 p.m., at the Academy of Medicine, 91 Lincoln Park, preceded by a board meeting at 1 p.m. Mrs. J. Irving Fort, President, presided.

Reports were made by the various chairmen and accepted.

Following the meeting "Health Institute Day" was held. Mrs. William Donahue, Chairman of the Public Relations Committee, introduced the speaker, Dr. Harvey Zorbaugh, Chairman of the Department of Educational Sociology of New York University. His topic was "Nerves at War".

Women from the various clubs were invited to attend this meeting.

Mrs. Joseph Clarken, Chairman of Ways and Means, announced that the annual dance would be held on Wednesday, April 23rd, at the Crestmont Golf Club.

At the close of the meeting tea was served with Mrs. Richard McDonald, of Paterson, President of the Woman's Auxiliary to The Medical Society of New Jersey, and Mrs. J. Irving Fort presiding at the tea table.

The Auxiliary honored the doctors' mothers, members' mothers and new members at a tea on Monday, April 28th, 2 p.m., at the Academy of Medicine, 91 Lincoln Park. A board meeting at 1 p.m. preceded the regular meeting, with Mrs. J. Irving Fort, the President, presiding.

Mrs. Clymount McArthur, Membership Chairman, proposed two new members.

The members voted a donation of \$500 to be given to the Doctors' Benevolent Fund, and \$50 to be given to the Red Cross.

Mrs. Joseph Clarken, Ways and Means Chairman, reported that the Spring Dance given on April 23rd at the Crestmont Golf Club was a success.

The slate was read and the following will take office at the Annual Meeting to be held on May 26th at L. Bamberger and Co., Newark:

President, Mrs. Edward W. Sprague
Vice-President, Mrs. Alton Schacter
President-Elect, Mrs. Asher Yaguda
Treasurer, Mrs. William Donahue

Directors: Mrs. Stuart Hawkes and Mrs. John Huberman

Dr. Herbert Thompson Strong, color consultant of the New York Museum of Science and Industry, gave a very interesting talk on "Exploring the Magic World of Color".

Mrs. George A. Rogers and Mrs. Don A. Epler presided at the tea table.

Gloucester County

Reported by Mrs. C. A. Bowersox, Public Relations Chairman

The *Woman's Auxiliary to the Gloucester County Medical Society* entertained at a Reciprocity Tea, Friday, April 25th, 2 p.m., at the Grove Lawn Tea Room in Clayton. Mrs. R. J. McDonald, of Paterson, President of the New Jersey State Medical Society Auxiliary; presidents of Federated Clubs, Parent-Teacher Associations and other organizations in the county were guests. There were about eighty present.

Mrs. Frederick G. Wandall, Chairman of the Program Committee, presented the guest speaker, Dr. Harry Rogers, of Riverton, a member of the Staff of Jefferson Hospital, who gave an enlightening talk on "Allergy".

Dr. Henry B. Diverty, of Woodbury, President of the Gloucester County Medical Society, also gave a brief talk.

The Auxiliary was entertained by Mrs. Carl Du Bois, reader, and Mrs. Fred Gravino, pianist. Tea was served by Mrs. Wandall and her committee.

Hudson County

Reported by Mrs. Sydney Chayes, Chairman of Publicity

The annual meeting of the *Woman's Auxiliary to the Hudson County Medical Society* was held on the afternoon of April 7, 1941, at the club rooms of the Jersey City Young Women's Christian Association, with the President, Mrs. Arthur Largay, presiding.

The following officers were elected:

President, Mrs. Joseph Ruvane, Jersey City
First Vice-President, Mrs. Edward Waters, Jersey City
Second Vice-President, Mrs. Samuel Scott, Jersey City
Recording Secretary, Mrs. Sydney Chayes, Bayonne
Treasurer, Mrs. Harry Perlberg, Jersey City.

May 19 will be the Annual Play Day, with luncheon and bridge at the Montclair Golf Club. Mrs.

William Friele and Mrs. Abraham Schulman will be in charge.

Tea was served after the meeting.

The *Woman's Auxiliary to the Hudson County Medical Society* held its last meeting of the season on May 5, 1941, in the parlors of the Young Women's Christian Association, Jersey City. The following officers were installed:

President, Mrs. Andrew Ruoff, Union City
President-Elect, Mrs. Joseph Ruvane
First Vice-President, Mrs. Edward Waters
Second Vice-President, Mrs. Samuel Scott
Recording Secretary, Mrs. Sydney Chayes, Bayonne
Treasurer, Mrs. Harry Perlberg.

Mrs. John Nevin presented Mrs. Arthur Largay, the retiring President, with a Past President's Pin of the Auxiliary.

After the business session the women enjoyed bridge, and tea was served by the following committee: Mrs. Frederick Finger and Mrs. H. Tartaryan, hostesses, assisted by Mrs. Charles Kelley, Mrs. Abraham Jaffin, Mrs. Harry Perlberg and Mrs. Joseph Ruvane.

Plans have been completed for the annual Play Day of the Auxiliary on May 19, when luncheon and bridge will be enjoyed at the Montclair Golf Club. Mrs. William Friele and Mrs. Abraham Schulman are co-chairmen.

Union County

Reported by Mrs. R. P. Blythe, Chairman of Publicity

The March meeting of the *Woman's Auxiliary to the Union County Medical Society* was held at the home of the President, Mrs. H. S. Murphy, of Roselle.

Dr. Watson B. Morris, President of The Medical Society of New Jersey, was the guest speaker. Dr. Morris spoke on the "Convention at Atlantic City". Following the meeting tea was served.

The annual meeting was held on April 8th at the home of Mrs. Alex Strelinger, Elizabeth, with the President, Mrs. Murphy, presiding.

Mrs. Lucile S. Meister, Public Contact Representative to the New Jersey Council of Housing Authorities, was the guest speaker. On April 25th the members will tour the Elizabeth projects, Mravlag Manor and Pioneer Homes. The tour will be preceded by luncheon at the Winfield Scott Hotel, Elizabeth.

Mrs. H. V. Hubbard, Plainfield, spoke on the Women's Field Army of the American Society for the Control of Cancer, and urged members to enlist.

Delegates to the N. J. Medical Society were named as follows: Mrs. H. V. Hubbard, Mrs. G. A. Seymour, Mrs. Charles H. Schlichter, Mrs. Rowland P. Blythe.

Alternates: Mrs. L. Armstrong, Mrs. William C. Meinecke, Mrs. Carl G. Hanson and Mrs. George Knauer.

Tea was served by the hostess.

BOOK REVIEWS

MANAGEMENT OF THE CARDIAC PATIENT. By William G. Leaman. Pp. 705 with 255 original illustrations, two in color. Philadelphia, J. B. Lippincott Company. 1940. \$6.50.

This book seems to the reviewer the best that he has read. The approach to therapy is interesting and well covered; as also are the types and treatment of heart failure and the chapters dealing with that important etiological factor, rheumatic heart disease. Angina pectoris and coronary artery disease, including thrombosis, are discussed with more than usual thoroughness. Hypertensive heart disease and the heart in thyroid disease are well described. Allergy and the heart, cardiac problems in surgical practice, and cardiac emergencies are unusual topics in a book of this kind. The latter subject seems to be most valuable, not only to the cardiologist but also to any practitioner who may encounter a cardiac emergency. The last chapter on electrocardiology is full of detail describing most of the different types of graphs with the aid of photographs.

The book is easy to read and should prove valuable to the general practitioner and specialist. It can be highly recommended to the practitioner.

FREDERICK A. ALLING, M.D.

SYNOPSIS OF THE PRINCIPLES OF SURGERY. By Jacob K. Berman, A.B., M.D., F.A.C.S., Assistant Professor of Surgery, Indiana University School of Medicine, Indianapolis. With 274 illustrations. St. Louis, The C. V. Mosby Company. 1940. Price \$5.00.

The author has written a synopsis packed full of information,—and it is surprising in such a compendium to find such extensive discussions of fluid balance, acid base balance, hemorrhage, and shock. The section on the later is extremely conservative, and will certainly lead to no trouble if followed. It would benefit by the addition of some of the more recent work on the effect of adrenal cortex extract and saline solution upon the arterioles and capillaries. The section on ulcer and gangrene is conspicuous by the lack of any information of the outstanding and well-known work of Meleney and his associates and the use of zinc peroxide.

The many illustrations and diagrams are well chosen, and greatly assist the reduction of necessary text. The bibliographies at the end of each chapter are as welcome as they are unexpected in a synopsis. The book should serve as a handy reference guide for the General Practitioner.

C. ABBOTT BELING, M.D.

CLINICAL PELLAGRA. By Seale Harris, M.D., and Seale Harris, Jr., M.D., with a foreword by E. V. McCollum, Ph. D., Sc. D., L.L.D. Pp. 494. St. Louis, C. V. Mosby Co. 1941. \$7.00.

This is more than a book on clinical pellagra. It is an excellent monograph by an outstanding student of the subject in collaboration with other bedside and laboratory investigators of pellagra, most of whom are connected with southern institutions. Each covers the allotted topic in a clear, masterly fashion, both from the clinical and from the experimental point of view.

The author first gives a complete historical and geographical resume of pellagra. Full credit is given to the pioneer investigations of Dr. Goldberger, the first to recognize pellagra as a deficiency disease. This is followed by a review of the different theories advocated at different times as to the etiology of the disease, coming down to our present-day conception of the extrinsic nicotinic acid factor, and the intrinsic liver factor.

When writing about therapy, the author takes on the spirit of a crusader, and justly so. He stresses the need for proper foods in the diet, not the high-pressure salesmanship of different vitamin preparations. Of course he properly evaluates and orders them when indicated.

On the whole, this is an excellent and profitable book to read. The print and paper are good; there are fine black and white, as well as colored, photographs.

N. B. HELLER, M.D.

METHODS FOR DIAGNOSTIC BACTERIOLOGY. By Isabelle G. Schaub, A.B., and M. Katherine Foley, A.B. Pp. 303. St. Louis, C. V. Mosby Co. \$3.00. 1940.

This book fills the need for a practical manual of bacteriological technic which includes the more recent procedures, but most of the methods outlined have stood the test of time. The careful arrangement and clear explanation of the subject matter demonstrate the wide experience and excellent critical judgment of the authors.

In our laboratory this book is in constant use by the bacteriologists as a reference work. It should be especially valuable in hospital and public health laboratories. References are given for many of the newer procedures and culture medias. There are no illustrations, but many charts are included. Blank pages for notes are apposite each printed page.

ARTHUR R. ABEL, M.D.

SUPPLEMENTARY LIST OF MEMBERS NO. 2

to the

OFFICIAL LIST OF MEMBERS, MARCH 15, 1941

The figures in parenthesis refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

ACTIVE MEMBERS

Axilrod, Maurice H., 2620 Pacific av., Atl. City (1)
Bew, Richard C., 1217 Pacific av., Atlantic City (1)
Brock, Howard F., 417 W. Broad st., Westfield (20)
Butler, Samuel S., 1100 Kaighn av., Camden (4)
Capell, Harry H., 87 Bridge st., Paterson (16)
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1. Knight, F., and Shelanski, H. A., "Treatment of Acute Anterior Urethritis with Silver Picrate," Am. J. Syph., Gon. & Ven. Dis., 23, 201 (March), 1939.

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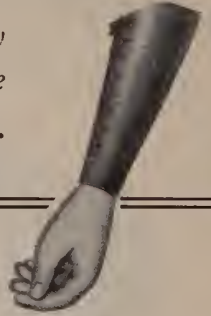
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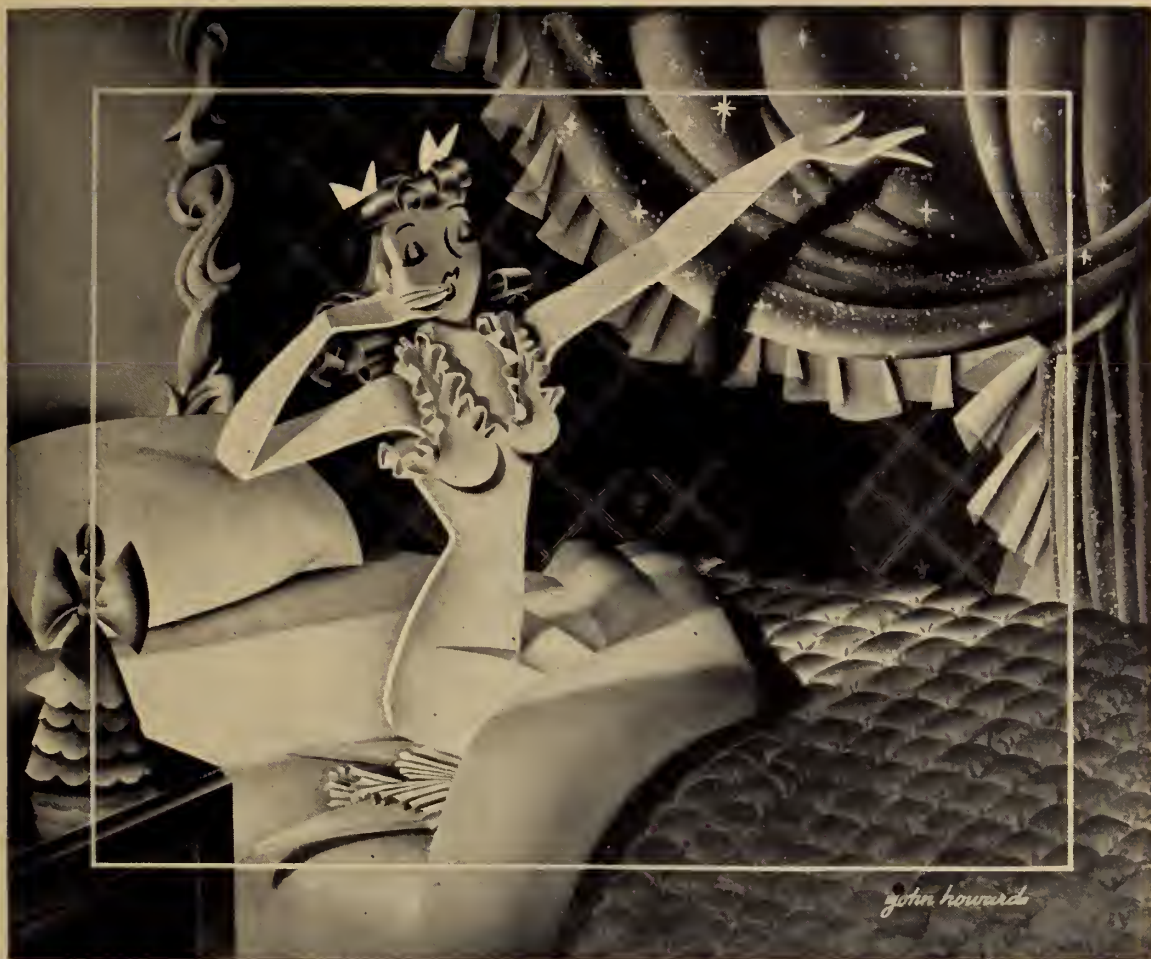
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Clinical observations of Strauss and McDonald lead to the conclusion that the condition is a dietary deficiency disorder similar to beriberi, caused by lack of vitamin B₁. They report recovery in their cases receiving this therapy, including dried brewers' yeast.

Hyperemesis as Cause of Avitaminosis

Wechsler observes that all cases of polyneuritis of pregnancy recorded in the literature were preceded by long periods of severe vomiting. "It would seem," he adds, "that because of actual starvation these patients suffered from avitaminosis and consequent neuritis," a view likewise held by Hirst, Luikart, and Gustafson. Plass and Mengert observe that the practice of giving high carbohydrate feedings for hyperemesis gravidarum is still more likely to cause avitaminosis.

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MERCER	Harold C. Cox, Hightstown	Phillipsburg 10-R-13 A. Dunbar Hutchinson, Trenton... Tel. 3-5542	A. Dunbar Hutchinson, Trenton
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BURLINGTON	F. D. Fahrenbruch	101 Garden St., Mt. Holly	237
CAMDEN	Edmund Hessert	417 Cooper St., Camden	3382
CAPE MAY	Clarence W. Way	Sea Isle City	55
CUMBERLAND	J. S. Knowles	318 N. Second St., Millville	52
ESSEX	Alfred Muerlin	158 S. Harrison St., East Orange	Orange 5-9026
GLOUCESTER	Chester I. Ulmer	Gibbstown	Paulsboro 18
HUDSON	John J. McCarthy	616 35th St., North Bergen	Palisades 6-2385
HUNTERDON	P. W. Baker	High Bridge	170-R-2
MERCER	James R. Harman	824 W. State St., Trenton	3-0436
MIDDLESEX	Charles H. Calvin	80 Commerce St., Perth Amboy	4-0941
MONMOUTH	William Heatley	23 Monmouth St., Red Bank	80
MORRIS	George L. Nicoll	48 W. Blackwell St., Dover	180
OCEAN	George W. Gaumer	422 First St., Lakewood	81
PASSAIC	Theodore K. Graham	279 Park Ave., Paterson	Sherwood 2-9422 and 1607
SALEM	William T. Hilliard	105 Market St., Salem	332
SOMERSET	Samuel H. Pogoloff	Manville	Scmerville 1228
SUSSEX	H. M. Aitken	Ogdensburg	Franklin 2002
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HOLLAND-RANTOS offers a most complete line of diaphragms. We invite inquiries concerning specific conditions.

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The H-R Koromex diaphragm (coil spring type) is available in sizes from No. 50 to No. 105 mm., and is indicated for use in all normal anatomies.

The H-R Mensinga diaphragm (watch or flat spring) is available in sizes from No. 50 to No. 90 mm. including half sizes, and is indicated where there is a slight redundancy of the mucosa of the retro pubic space, or a slight relaxation of the anterior vaginal wall.

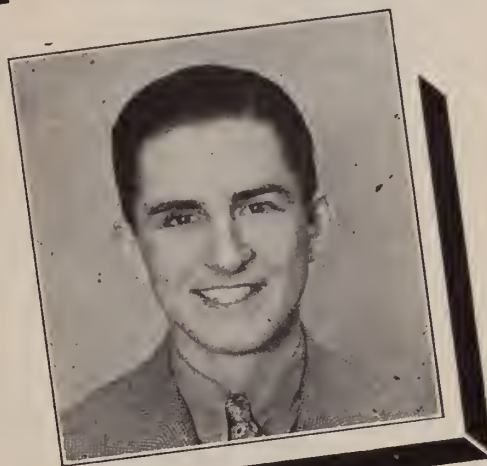
The H-R Matrisalus diaphragm is available in sizes—No. 1 to No. 6 corresponding to 65, 70, 75, 80, 85 and 90 mm. This special shaped diaphragm is indicated in cases of cystocele or prolapse where, owing to relaxed vaginal walls, the ordinary diaphragm cannot be retained in position.

*Send for copy of "Physician's Diaphragm Chart
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Full-Motioned, Lifelike **ARTIFICIAL HUMAN EYES**



We have the Enviably Reputation of "Really Knowing How" to produce that "Pleasing Cosmetic Effect" so desired by one wearing an Artificial Eye.

REFERRED CASES CAREFULLY ATTENDED

IT IS OF VITAL IMPORTANCE TO THE PATIENT'S FUTURE APPEARANCE THAT THE FIRST ARTIFICIAL EYE BE PROPERLY FITTED. IT IS IN THESE NEW CASES, WHERE UTMOST ATTENTION MUST BE GIVEN—AND OF WHICH WE HAVE MADE A SPECIAL STUDY.

Espécially Made to Order Eyes by Skilled Artisans.

Also Eyes Fitted from Stock

SELECTIONS SENT ON MEMORANDUM UPON REQUEST.

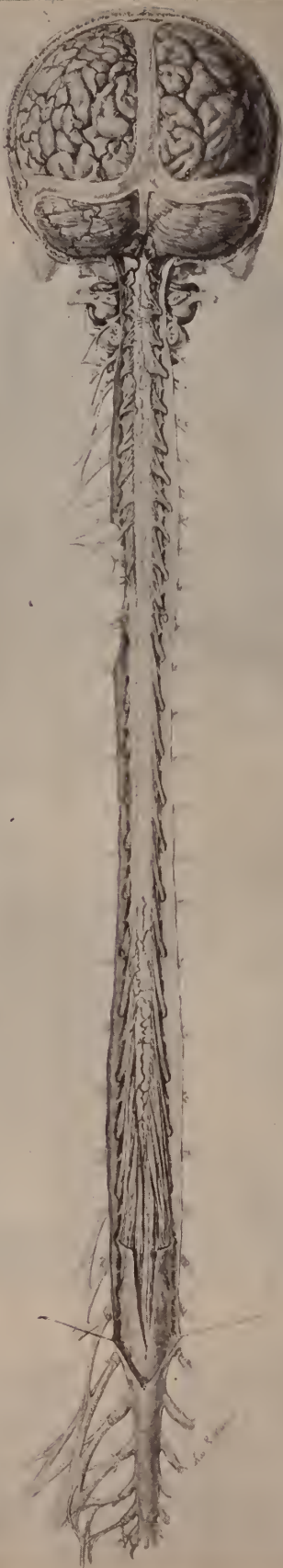
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"Specialists in Artificial Human Eyes Exclusively"

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In Syphilis of the Central Nervous System

TRYPARSAMIDE MERCK

● THERAPEUTIC ADVANTAGES

Unusual power of therapeutic penetration in case of the central nervous system.

Varying degrees of symptomatic improvement obtained in a large proportion of early cases of dementia paralytica.

Found useful in the treatment of tabes dorsalis, meningeal and other forms of neurosyphilis.

Especially recognized in conjunction with fever therapy.

● ECONOMIC ADVANTAGES

Easily administered by usual intravenous technic.

Available for private practice, clinic and hospital use.

Supplied in ampuls of definite dosage.

Inexpensive.

For 20 years Tryparsamide Merck has been available for use in the treatment of neurosyphilis. It is supplied to the medical profession through leading pharmacists in 1, 2, and 3 Gm. ampuls for private practice use. The low cost of Tryparsamide Merck makes it available to practically every patient.

Literature on Request

MERCK & CO. Inc.

Manufacturing Chemists

RAHWAY, N. J.

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MERCK**

COUNCIL



ACCEPTED

*An outstanding
therapeutic agent
in neurosyphilis*

PROFESSIONAL LIABILITY PROTECTION

Afforded Members of

THE MEDICAL SOCIETY OF
NEW JERSEY

Since 1931

FAULHABER & HEARD, INC.

Authorized broker to negotiate
professional liability contracts for
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Kindly send information on limits and costs of Society Professional Policy.

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Address

.....

THESE NAMES, THESE YEARS...
HAVE HELPED MAKE MODERN MEDICAL HISTORY

1909 Sørensen studies hydrogen ion concentration.
Russel inoculates United States soldiers against typhoid.
Marine and Lenhart investigate iodine treatment of goiter.
Parke, Davis & Company introduces Pituitrin, the first standardized pituitary extract.

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TO MEDICINE
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One of a series of advertisements commemorating three-quarters of a century of progress and achievement

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PIONEERS IN RESEARCH
ON MEDICINAL PRODUCTS



Q. I've noticed that some cans are golden-colored on the inside. Why is that?

A. You've probably noticed that kind of lining on cans for colored products. It's put there to protect their quality principally from a color standpoint. You'll also notice it on certain vegetables and meats. For other products, a plain tin lining is entirely suitable. The lining of the can is adjusted to the needs of the individual food. These can linings are special inert enamels baked onto the tin plate at high temperatures. ⁽¹⁾

⁽¹⁾ 1941. Canner 92, No. 12, Pt. 2, pages 78-81. 1936 Canner 82, No. 11, Pt. 2, pages 104-105.



The Seal of Acceptance denotes that the nutritional statements in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

INDIVIDUALIZED FORMULAS FOR THE NEWBORN

NORMAL INFANTS

Whole milk 10 ozs.
Water, boiled 10 ozs.
Karo syrup 2 tbs.

Evaporated milk 6 ozs.
Water, boiled 12 ozs.
Karo syrup 2 tbs.

Powdered milk 5 tbs.
Water, boiled 20 ozs.
Karo syrup 2 tbs.

ALLERGIC INFANTS

Evaporated goat's milk . . . 6 ozs.
Water, boiled 12 ozs.
Karo syrup 2 tbs.

Hypoallergic milk 10 ozs.
Water, boiled 10 ozs.
Karo syrup 2 tbs.

Sobee 8 tbs.
Water, boiled 18 ozs.
Karo syrup 2 tbs.

NEUROPATHIC INFANTS

Evaporated milk 7 ozs.
Water, boiled 13 ozs.
Barley flour 3 tbs.
Karo syrup 1 tbs.
(cooked ten minutes
until thick)

Whole milk 12 ozs.
Water, boiled 6 ozs.
25% Lactic acid 2 tsp.
Karo syrup 2 tbs.

2% Lactic-acid milk 18 ozs.
Karo syrup 2 tbs.

*"Infants Thrive
on Karo Formulas"*



Newborns tolerate a simple formula consisting of 10 ounces of boiled fresh cow's milk, 8 ounces of sterile water and 1 ounce of mixed sugar. Added carbohydrate in the form of corn syrup is usually better tolerated than the simple sugars, lactose or sucrose. At first, about one ounce of the formula will be taken at a time although the infant is allowed all he will take of the three ounces and the remainder discarded. The allergic newborn may be given evaporated cow's-milk or goat's-milk formulas; the hypertonic newborn thick feeding; the hypotonic newborn, evaporated or lactic-acid milk formulas."

KUGELMASS: *"Newer Nutrition in Pediatric Practice."*

THE CHEMICAL COMPOSITION OF KARO IN GLASS AND IN TINS IS IDENTICAL

Dextrins.....37.4%	1 oz. volume.... 40 grams
Maltose.....18%	120 cals.
Dextrose.....12%	1 oz. wt..... 28 grams
Sucrose.....4%	90 cals.
Invert Sugar.....3%	1 teaspoon..... 20 cals.
Minerals.....0.6%	1 tablespoon.... 60 cals.
Moisture.....25%	

(Karo—Blue Label)

CORN PRODUCTS SALES COMPANY

17 Battery Place, New York City



MUST I WEAR GLASSES??

How often do your patients ask this question? Doctor, who is to decide?

Play Safe, refer them to an Eye Physician, you can rely upon his advice as he has your patient's health and comfort in mind.



EYE PHYSICIANS: *Your prescriptions for glasses are "Safe" when referred to a Guild Optician.*

Guild of Prescription Opticians of New Jersey, Inc.

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552 Cookman Ave.

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344 Springfield Ave.

WESTFIELD
BRUNNER'S
206 Broad St.

*palatable • nutritious
... easily assimilated—*

Lederle's CEREVIM

CEREVIM IS A CEREAL FOOD, formulated by pediatricians to provide suitable nutritive values for babies and children. It is distinctly appetizing, easily digested and non-irritating.

AIDS IN PROMOTING GROWTH: In comparative clinical studies* it was shown that Cerevim-fed babies gained more weight and height than the control babies on their usual cereal.

HELPFUL IN ANOREXIA AND CONSTIPATION: Cerevim was observed in the study* to stimulate the appetite in anorexia and relieve constipation in children suffering from these two common childhood complaints.

FOR INVALIDS AND CONVALESCENTS: Gastro-enterologists prescribe Cerevim for peptic ulcer patients or those in need of a bland diet of low fibre content. Obstetricians prescribe Cerevim during pregnancy and lactation; surgeons order it for pre-operative and post-operative diets.

COMPREHENSIVE FORMULA: Cerevim's comprehensive formula provides proteins, carbohydrates and fats in a suitable ratio; calcium, phosphorus, iron and copper in easily assimilated form; and the B vitamins in generous amounts—all derived from natural sources only.

Advertised only to the medical profession. Council-Accepted.

Sold only through drug stores.

Pre-cooked and ready for instant use.

Packages: Cerevim is sold in
½ and 1 lb. packages.

*JOSLIN, C. L. and HELMS, S. T., Arch. Ped., 54:533 (Sept.) 1937



LEDERLE LABORATORIES, INC.
30 ROCKEFELLER PLAZA • NEW YORK, N. Y.



A Reminder from Borden about

FORMULA FLEXIBILITY



- Dryco offers the physician maximum flexibility in adapting his formulas to the needs of individual infants.

Because of its low fat and high protein content, Dryco can be used alone, or with your preferred carbohydrate addition; or in combination with other milk sources—Klim, fluid milk, Evaporated milk—to give a desired balance of fat and protein.

Dryco is irradiated powdered milk, adjusted as to fat and protein balance to compensate for the difference between cow's milk and breast milk. It has been found successful in clinical experience for more than 20 years.

The Borden Company, 350 Madison Avenue, New York City



Borden's DRYCO

A BORDEN PRESCRIPTION PRODUCT



Dear Doctor
 Why don't you
 follow the advice you
 so often give others?
 It would do you a
 world of good, and



**ALL-EXPENSE
 38-DAY CRUISES**
to the Fascinating East Coast of
SOUTH AMERICA

See new peoples, new places, new wonders of nature. Forget the aches and pains of others and do a little whole-hearted relaxing on your own behalf. There's a cruise sailing every fortnight from New York.

33,000-TON AMERICAN REPUBLICS LINERS

S. S. BRAZIL S. S. URUGUAY
S. S. ARGENTINA

Planned and manned to offer every shipboard comfort—every cruise pleasure. All staterooms outside, air-conditioned dining rooms, broad Lido sports decks with outdoor tiled swimming pools, spacious public rooms, lavish programs of entertainment.

Cruise Rates: \$395 Tourist, \$550 First Class (\$585 certain seasons). Rates include all shore excursions and hotel expenses at Buenos Aires, ship is your hotel at all other ports.

Consult Your Travel Agent or

MOORE-McCORMACK
Lines

5 Broadway, New York

R The Itinerary
 is a Perfect
 Prescription

BARBADOS
 RIO DE JANEIRO
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 MONTEVIDEO
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THE NATURAL MINERAL WATERS OF SARATOGA SPA ARE
OWNED AND BOTTLED BY THE STATE OF NEW YORK



SARATOGA SPA GEYSER WATER

to

Stimulate the Secretory Action of the Stomach

The medicinal Waters of Saratoga Spa, by reason of their natural carbonation, are stimulating to the mucous membranes of the upper gastrointestinal tract.

Of the three Spa Waters, bottled by the State, Saratoga Geyser — the alkaline-saline — is first in consideration for the above-mentioned purpose. It is bland, exceptionally palatable, yet richly mineralized. Its natural supersaturation with Co_2 makes it an appetizing and refreshing beverage.

Geyser Water is indicated for conditions where the physician desires to fortify the alkaline reserve, and to stimulate the secretory activity of the stomach. Patients with poor appetites and many in the rheumatic group are included here.

Geyser and the other Spa Waters for internal use are discussed in Spa Publication No. 9—of which a copy will be sent gladly, on request. For clinical trial a 4-bottle Physician's Sample assortment will also be sent if you wish. Write, on your professional letterhead, to W. S. McClellan, M.D., Medical Director, Dept. 159, Saratoga Spa, Saratoga Springs, N. Y.

Analysis of the Three Waters

(MINERAL PARTS PER MILLION)

Hypothetical Combinations	Geyser Water	Hathorn Water	Coesa Water
Ammon. chlorid	48.25	59.10	33.30
Lithium chlorid	21.07	64.49	46.43
Potass. chlorid	361.91	789.54	714.86
Sodium chlorid	2,010.48	8,594.84	4,233.14
Potass. bromid	9.23	160.00	13.90
Potass. iodid	1.10	4.80	1.36
Sodium sulphate	None	None	None
Sod. metaborate	Trace	None	Trace
Sodium nitrate	Trace	Trace	Trace
Sodium nitrite	Trace	Trace	Trace
Sodium bicarb.	2,213.78	424.71	1,331.15
Calcium bicarb.	1,829.14	3,380.84	2,519.74
Barium bicarb.	16.67	25.65	25.00
Strontium bicarb.	Trace	Trace	Trace
Ferrous bicarb.	9.94	40.07	5.86
Magnes. bicarb.	753.89	2,244.88	1,186.57
Alumina	7.14	4.98	6.37
Silica	19.49	14.40	12.80
Total	7,284.00	15,808.30	10,130.48

Look for the Seal of The State of New York on every bottle of the genuine waters of Saratoga Spa.



THE BOTTLED WATERS OF
SARATOGA
SPA

GEYSER • HATHORN • COESA



For the local Treatment of Acute Anterior Urethritis

(DUE TO NEISSERIA GONORRHEAE)



A complete technique of treatment and literature will be sent upon request

*Silver Picrate is a definite crystalline compound of silver and picric acid. It is available in the form of crystals and soluble trituration for the preparation of solutions, suppositories, water-soluble jelly, and powder for vaginal insufflation.

Silver Picrate, Wyeth, has a convincing record of effectiveness as a local treatment for acute anterior urethritis caused by *Neisseria gonorrhoeae*.¹ An aqueous solution (0.5 percent) of silver picrate or water-soluble jelly (0.5 percent) are employed in the treatment.

1. Knight, F., and Shelanski, H. A., "Treatment of Acute Anterior Urethritis with Silver Picrate," *Am. J. Syph., Gon. & Ven. Dis.*, 23, 201 (March), 1939.

JOHN WYETH & BROTHER, INCORPORATED, PHILADELPHIA



COMFORT - The Yardstick by which your Cardiac Patient Measures his Progress

Theocalcin (Council Accepted) helps to bring comfort to cardiac patients by promptly reducing edema, diminishing dyspnoea and strengthening heart action. Theocalcin is given orally in doses of 1 to 3 tablets, t. i. d.

Theocalcin is a well tolerated Diuretic and Myocardial Stimulant.

Available in 7½ grain tablets and in powder form.



Theocalcin, brand of theobromine-calcium salicylate.
Patent and Trade Mark Reg. U. S. Pat. Off.

BILHUBER-KNOLL CORP. ORANGE, NEW JERSEY.

For Fall Hay Fever SQUIBB POLLEN EXTRACTS



STARTING with August and until the time of frost, the wind-borne weed pollens are the chief offenders in causing hay fever. The following Squibb Allergenic Extracts, depending on locality, are useful at this season:

Ragweed Combined	Shadscales
Cocklebur	Wormwoods
Ragweed and Cocklebur Combined	Sheep Sorrel
Russian Thistle	

These are supplied in 5-cc. vials—which, when used with the Special Diluent Package, offer an economical means of reducing the sensitivity of hay fever sufferers.

Very convenient, too, is the three-vial package of Ragweed Combined and Ragweed and Cocklebur Combined.

Squibb Allergenic Extracts are highly potent, stable and uniform in dosage. They are standardized in protein nitrogen units. This unit has been shown by Cooke and Stull¹ to be a very close measure of allergenic activity.

Special Prescription Combinations

A service is available to physicians whose patients require combinations of pollen extracts not regularly supplied or in special proportion.

Physicians are invited to write concerning their problems in treating patients with hay fever. Our experience of over twenty years in making Pollen Extracts may be most helpful. Address the Medical Department, E. R. Squibb & Sons, 745 Fifth Ave., New York, N. Y.

¹ Cooke, R. A., and Stull, A.: *J. Allergy* 4: 87, 1933.

E·R·SQUIBB & SONS

Manufacturing Chemists to the Medical Profession Since 1858

54% of our customers are sent to us by doctors

● 54% of Walker-Gordon customers tell us they started taking Walker-Gordon Certified Milk upon the advice of their physicians.

One of the reasons why the medical profession recommends Walker-Gordon Certified Milk is this:



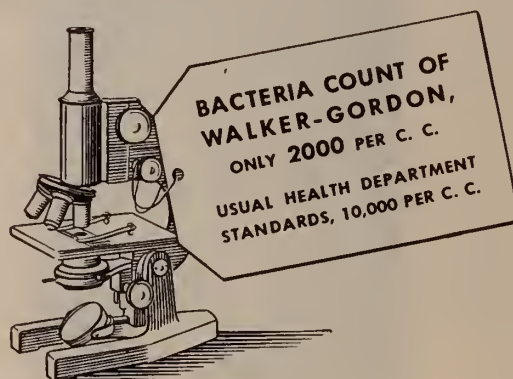
During cold months Walker-Gordon contains 60% more Vitamin A than regular milk.

During the winter and early spring months when most doctors consider an adequate supply of



Vitamin A most important, Walker-Gordon contains 60% more Vitamin A than regular milk.

The Vitamin A content is so high because the cows are fed a balanced ration of 16 foods—including dehydrated, summer-rich alfalfa rather than ordinary hay in the winter.



Another reason why doctors recommend Walker-Gordon Certified Milk is its exceptional purity.

Being produced entirely on our farm under the strictest sanitary control in the industry, the bacteria count of Walker-Gordon Certified Milk averages only 2000 per c.c. at time of bottling, compared to medical and health department standard requirements of 10,000 per c.c. Samples taken regularly from the bottling line show a complete absence of pathogenic bacteria.

Walker-Gordon Certified Milk

THE WORLD'S FINEST MILK

AVAILABLE EITHER UNHEATED, PASTEURIZED, OR HOMOGENIZED

For Comforting Relief in Asthma and Hay Fever

Racēphedrine Hydrochloride

(UPJOHN)

Racēphedrine Hydrochloride produces dilation of the bronchi after local or systemic administration. It is therefore employed in the treatment of asthma, and is useful to prevent the attacks. It is also used in the treatment of hay fever and urticaria.

On local application to mucous membranes, Racēphedrine contracts the capillaries to a moderate degree and thus diminishes hyperemia and reduces swelling. It is used in the nostrils to shrink the congested mucosa in rhinitis and sinusitis.

Solution Racēphedrine Hydrochloride consists of 1% of the drug in a modified Ringer's solution containing sodium chloride 0.85%, potassium chloride 0.03%, calcium chloride 0.025%, magnesium chloride 0.01%, and chlorobutanol 0.5% (for stabilization purposes).

Solution Racēphedrine Hydrochloride 1% is available in one ounce dropper bottles for prescriptions, in pint bottles for office use. Capsules Racēphedrine Hydrochloride, $\frac{3}{8}$ grain, are packaged in bottles of 40 and 250.



FIN PHARMACEUTICALS SINCE 1886

Upjohn
KALAMAZOO, MICHIGAN



Racēphedrine, prepared symmetrically by a process which does not depend upon the plant ma huang for its raw material, is a racemic, optically inactive mixture of levo- and dextro-rotatory ephedrine. Thus it contains two of the four possible ephedrine stereoisomers.

Step toward Perfection

Crude drugs and chemicals procured for the preparation of Lilly products must measure up to highest standards. Assays from outside sources, no matter how reliable, never are accepted without confirmation from the Lilly control laboratories.

LIVER EXTRACTS **Crude or Purified** **For Intramuscular Injection**



SOLUTION LIVER EXTRACT CRUDE, LILLY

2 injectable U.S.P. units per cc.

1 injectable U.S.P. unit per cc.

SOLUTION LIVER EXTRACT PURIFIED, LILLY

15 injectable U.S.P. units per cc.

10 injectable U.S.P. units per cc.

5 injectable U.S.P. units per cc.

ELI LILLY AND COMPANY

Principal Offices and Laboratories, Indianapolis, Indiana, U. S. A.

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

PUBLISHED MONTHLY SINCE SEPTEMBER, 1904

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UNDER THE
DIRECTION OF THE
COMMITTEE ON PUBLICATION



HENRY C. BARKHORN, M.D., Chairman

HENRY A. DAVIDSON, M.D., Editor

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VOL. XXXVIII, No. 7

JULY, 1941

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Single Copies, 30 Cents

MESSAGE FROM THE PRESIDENT

It is our purpose to make every effort to see that New Jersey shall continue to hold No. 1 position in Medical Preparedness.

Almost every advisory committee has a definite task in this preparedness program. The details are of such magnitude that for the Committee on Medical Preparedness alone it will be an impossible task. It is, therefore, our plea that each Advisory Committee, in addition to its own previously established activity, take on that share of preparedness work allotted to it, and be prepared to co-operate with the Preparedness Committee.

The *Committee on Adult Health Supervision* should study causes for rejections in selective service, plan for rehabilitation of rejectees and suggest preventive medicine procedures.

Prophylactic measures must be promoted and applied in industrial groups. This problem is to be worked out in conjunction with the *Committee on Industrial Health and Hygiene*.

The *Committee on Cancer Control* should make continued efforts at the

establishment of Cancer Clinics. We suggest a study to determine how many late cases might have been cured by surgery or radiation if diagnosis had been established earlier.

The *Child Health Committee* should study causes of army rejections that go back to preventable conditions, physical or dietary, in childhood. This committee should recommend basic diets for children in evacuee camps, and make plans for physical education, exercise or organized play in such camps.

The *Committee on Conservation of Vision* should analyze visual defects as a cause of army rejections, and should study school data on visual defects.

The findings and recommendations of the investigation should be widely publicized through our *Public Relations Committee*.

The *Crippled Children Committee* should prepare a "set-up" for care of orthopedic cases, the result of bombings and other disasters. This should begin with first aid treatment (the committee should assist in the preparation of the

new first aid manual), emergency accumulation stations, transportation, and the selection of hospital sites in non-vulnerable areas. It should prepare specifications for orthopedic hospitals for permanent treatment and rehabilitation of orthopedic cases.

The *Maternal Welfare Committee's* program should include: (1) Prenatal care in disaster areas. (2) Scheme for emergency deliveries in devastated areas, and (3) location of hospitals in non-vulnerable areas.

The *Mental Hygiene Committee* might work on the problem of morale, entertainment and diversion in evacuee camps, and on the program of rehabilitation camps for war neuroses.

The *Pneumonia Control Committee* must work out preventive measures in evacuee camps, bomb shelters and in devastated areas, and standardize treatment in such areas. It should study the basic laboratory equipment necessary for pneumonia treatment and control.

The *Tuberculosis Committee* will be interested in case finding in evacuee camps and bomb shelters, and in the methods of segregation of open cases.

The *Traffic Accidents Committee* should plan for first aid post and shock hospitals (necessary equipment, etc.) along the line of evacuation routes.

The *Venereal Disease Committee* might plan for V.D. posts in evacuee camps and along routes of evacuation, and should analyze the incidence of venereal disease between the time of examination by local boards and time of induction.

The *Committee on Auxiliary Medical Services* will study the problem of basic laboratory equipment and personnel for mobile unit in truck, ambulance or automobile, to be used in disaster or in evacuee camps, including mobile x-ray units and anaesthetics for use in disasters or in evacuee camps.

The *Committees on Contract Practice, Industrial Health and Hygiene, Medical Care of Indigent and Low Wage Group,*

and *Workmen's Compensation* should plan for care to disaster groups, mushroom villages resulting from rapid expansion of war-time industry and evacuee camps. It should plan for the care of lay workers injured during disaster, and formulate contracts with state or other government authorities for medical care and pension of lay and professional workers injured while on duty in disaster relief work.

The *Hospital Relationships Committee* should study equipment required for operation of emergency hospitals resulting from disaster or mass evacuation—on unit basis, as well as the staff requirements of such hospitals.

The *Committee on Nursing and Nursing Education* might plan a basic course of training for women who volunteer to serve in emergency.

The *Pharmaceutical Problems Committee* should study zoning, location, number and equipment of pharmaceutical dumps, and formulate plans for the supply of drugs, narcotics, antiseptics, anaesthetics, diphtheria antitoxin, biologicals, and dressings.

The *Woman's Auxiliary* should set up emergency nursing groups to serve in emergency hospitals, operating room teams, obstetric teams made up of lay members and R.N.'s, clerical teams—for hospital operation, emergency feeding squads, specifically for medical and nursing personnel not otherwise cared for; transportation squads, for moving equipment, personnel of hospitals, messengers for professional staff of hospitals, and welfare squads to look after the families of physicians and members of Woman's Auxiliary who are occupied in disaster relief work.

It is recognized that many of the above activities parallel the work outlined by the Red Cross. Therefore, it is to be understood that the activities will be confined to the establishment, operation and support of emergency medical services.

THOMAS K. LEWIS, M.D., President,
Medical Society of New Jersey.

THE SPREAD OF DISEASE . . . AND RELIGIOUS FREEDOM

With the spurious justification of "religious freedom", New Jersey may soon be encouraging the spread of communicable disease. Such, at least, will be the State's claim to fame if the emasculated version of Assembly Bill 402 is finally enacted into law. In its original form, this Bill introduced by Mr. Hargrave, would allow no-one but physicians to treat venereal disease. The Christian Scientists succeeded in slipping an amendment into the bill which would exempt them from this restriction, thus allowing them to "treat" syphilis and gonorrhea! Only Senator Summerill of Salem voted against this amendment. The bill is now back in the Assembly, and it may be necessary for the friends of public health to withdraw A-402 entirely rather than see it enacted in its present vicious form.

The theory that religious freedom justifies faith healing in venereal disease is utterly false. First, it must be remembered that syphilis and gonorrhea are communicable diseases, and thus their control is a public health problem, not one of private religious opinion. Second,

it must be understood that the precious American right to worship according to one's own conscience can not be perverted to a permission to jeopardize public safety. To take an extreme but pertinent example, could the State allow a religious cult which prescribed assassination of non-believers, to flourish? Could murderers be given immunity in such a case, because their crimes were dictated of their religion? The question answers itself. Yet it is not too strong to say that the faith-healers will become public menaces if this amendment is enacted into law. Carriers of syphilis or gonorrhea who do not want to submit to medical care, will be allowed to spread their infection freely while undergoing the mumbo-jumbo of a cult "cure".

The incredible success of this wierd amendment can be explained only on the assumption that our Senators simply did not understand the implications of their approval. They should somehow be enlightened before New Jersey becomes an object of nation-wide derision by the enactment of the Christian - Science Amendment to the Venereal Disease law.

STAFF ROOM ORACLE

You must know him. There is one in every hospital. He sits in the staff room for an hour or two, enthroned in the most comfortable chair, and delivers weighty opinions on topics of the day. While the other doctors are periodically pulled out of the room by the clang of the telephone or the summons of an intern, the Oracle remains undisturbed. Somehow no one seems to be calling *him* on business.

First he polishes off the war. Explains what Churchill ought to do and what Hitler intends to do. He next settles problems on the Washington front. Tells General Marshall how the draft army ought to be organized and advises Secretary Knox to build more destroyers and

fewer battleships. Having disposed of that, he gives some attention to matters medical.

And this is where we come in. First he tells his transient audience what is wrong with the A.M.A. After explaining how it can earn his favor, he turns his high-powered intellectual spotlight on the State Medical Society. He thinks it spends too much of his money on this, and gives too little attention to that. "Now if I were running The Medical Society of New Jersey, I'd——"

All right, Doctor, stop right there. You *are* running The Medical Society of New Jersey. You and your 4000 medical colleagues. If you have any views on the

conduct of the Society's affairs, you have ample opportunity to express them where they can do the most good. Should your views concern fundamental policy, you can get up on your two legs at the next County meeting, and ask the local Society to instruct its Delegates. If you can persuade your fellow practitioners of the merit of your case, your Delegates will convey your ideas to the next meeting of the House. And if they are sound, the ideas will be accepted by the House of Delegates, which after all, is composed of perfectly reasonable men, willing to listen to any proposal that might help the Society.

Too long a procedure, you say. True, the democratic process is often a bit cumbersome, but this is no time to start advocating parliamentary short-cuts in the name of "efficiency".

And if your idea concerns an administrative technique rather than a fundamental policy, you can call it to the attention of the executive officers of the Society even more swiftly.

Here is how: pull over a piece of stationery and reduce your thoughts to writing. Don't waste them on an ever-changing audience in your own little staff-room. Seek a wider forum—where your ideas have some chance of translation into action. Just summarize your plans for the improvement of the Society, your grievances against present procedures, or your suggestions for change, and send them to the Editor of the *Journal*. The address is 143 East State Street, Trenton. We will publish your suggestions, so that your colleagues can read them and talk them over; and we will transmit them to the Society's officers as well.

Writing to the Editor is a good old American custom. Sometimes when you propound your ideas in the staff room, your brethren snicker: "Hire a hall!" And you *can* hire a hall, too. The pages of the *Journal* are open to you for that purpose. It is your forum, Doctor; the floor is all yours. What were you about to say?

COMMITTEE OF THE WHOLE

In his address to the anniversary meeting of the Middlesex County Medical Society last month, President Lewis announced that the membership of The Medical Society of New Jersey would be constituted a committee of the whole for the purpose of implementing the work of both the Medical Preparedness Committee and the program of the Medical Service Administration.

And of course, as an organization we *are* a committee of the whole. But in another sense, each of us is a committee of one. Each doctor is, to everyone he meets, the personification of Organized Medicine. The layman on whom I make a good impression thinks that the medical society must be all right, because he thinks of the society as being only myself in plural. And the layman on whom I

register badly, thinks that organized medicine must be an unworthy agency, since he judges that they are all as evil as I. Just as lawyers are taught that they, as individuals, are officers of the court, so we must learn, that doctors *as individuals* are representatives of the medical profession. For here is public relations reduced to its essence: it is, if you choose, private relations—private relations between you, the individual M.D., and each individual member of the public with whom you have contact. The multiplication of these "private relations" makes up our "public relations". And the total-ity can be no greater, and no better, than the sum of its parts. Think it over.

CHARLES M. ROBBINS, M.D.,
Chairman, Public Relations
Committee.

ORIGINAL ARTICLES

REGIONAL ILEITIS *

By HENRY REICH, M.D., F.A.C.S., Newark, N. J.
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and

MAX DANZIS, M.D., Newark, N. J.

Read before the Section on Gastro-enterology of the Annual Meeting of The Medical Society of New Jersey
in Atlantic City on June 6, 1940.

The publication in 1932 by Crohn and his associates of their experience with a group of cases of chronic inflammatory disease of the small bowel established an apparently new clinical entity and was the precursor of an unusual number of reports of similar cases by surgeons from all parts of the country. From an investigation of the literature, however, it is evident that there had been prior reports describing similar pathologic changes occurring within localized areas of the bowel. We ourselves can recall a patient upon whom we operated in 1927 in which we made a diagnosis of hyperplastic tuberculosis of the terminal ileum; but in retrospect, we believe that the patient had a regional ileitis. Despite these isolated case reports of the past, Crohn and his workers are rightly credited, because they stimulated a widespread interest in this condition.

The descriptions of the lesion in its various stages, as given by the many recent authors, are in the main identical, but the terminology has varied, so that today we have a multiplicity of names which is often confusing. Though there may be no unanimity of opinion as to the best nomenclature, all writers agree that this disease process is not necessarily limited to the terminal ileum, as originally thought, nor even to the ileum itself. From our own small group of cases it is evident that the disease may be present in the jejunum or the large bowel, independently or in conjunction with the terminal ileum, which segment is admitted to be the most common location. In four of our cases the process was at first limited to the terminal ileum. In one of these the disease

later spread proximally to involve areas of the jejunum; in another case there was a rapid spread distal to the anastomosis in the transverse colon. One of our cases had a right-sided regional colitis; another had x-ray findings indicative of involvement of the terminal ileum and cecum.

The etiologic factors are as undetermined today as ever. It is the opinion of most reporters that infection plays an important rôle, but no one organism can be said to be the sole cause of this pathologic process. However, it is quite well determined that the tubercle bacillus is not involved.

We have been impressed with the possible relationship of *allergy* to this disease. One of our proven cases of ileitis manifested numerous allergic phenomena which were investigated, but with inconclusive results.

CASE REPORT

Another patient who has a clinical history typical of this disease has definitely been shown to be a true case of allergy. This young girl began complaining of abdominal pains when seven and a half years old. These gastro-intestinal upsets were thought to be appendiceal in origin and after several attacks appendectomy was advised. At the operation a thickened, adherent appendix was found, and further exploration was not done. The post-operative period of well-being, however, was short lived, for the preoperative complaints soon recurred; in fact they became more severe, for vomiting and spells of diarrhea now occurred. She was thoroughly worked up by several competent gastro-enterologists, and though the x-ray films were not conclusive, one of these men was of the opinion that this was most probably a case of regional ileitis. Because the evidence was not conclusive enough to warrant surgical intervention, dietary measures were advised. The patient was tested for food allergy, but no definite results were obtained.

About two years ago, when the patient was

* From the surgical service of Dr. Max Danzis.

twelve, it was suggested that milk and milk products be eliminated from her diet, though there had been no evidence of her being allergic to milk. Almost immediately all her symptoms cleared up, and she has remained fairly well since then. On several occasions she has taken small quantities of milk, and each time there was a recurrence of the entire train of symptoms simulating an ileitis.

It is interesting to speculate upon the influence heredity may have in this condition. Crohn has on three occasions seen the disease in two members of a family, and two of our cases occurred in sisters. Investigating the family history of these two girls, we find that their paternal grandmother suffered for years from an intestinal disorder which was thought to be tuberculous in origin, but never conclusively proved. However, from the course of the disease, and a description of the symptoms, as obtained from her physician, we believe she may have had a regional ileitis. One first cousin, a female aged twenty-eight, has for the past few years had symptoms typical of ileitis, though x-ray findings are inconclusive. The young girl whose story was outlined above, is also closely related.

The clinical course of this disease varies greatly and is dependent upon the progress of the pathologic processes in the bowel. In our small group of seven cases we have seen all four types described by Crohn and his associates. In four of our patients we have seen the acute inflammatory stage limited to the terminal 10-12 inches of ileum. The process stopped abruptly at the ileo-cecal valve, and the involved bowel was markedly thickened, vivid red in color, and hose-like in consistency. The subjacent mesentery was edematous and weighted with visibly enlarged lymph nodes. One of these patients later developed a fecal fistula, and a second patient showed definite signs and symptoms of obstruction.

Another case came to our attention because of a perineal abscess, which eventually formed a recto-vaginal fistula. Upon further investigation a localized inflammatory lesion was found in the mid-portion of the transverse colon, an example of regional colitis.

DIAGNOSTIC POINTS

The diagnosis of ileitis is most difficult in those cases simulating acute appendicitis. However, in reviewing the histories of three of our patients who were operated upon for a supposed acute appendicitis, we find in each of them a statement which may be of some significance. Each of these patients complained of

a more or less persistent, dull backache. The chief complaint was abdominal pain, but each one had sufficient backache to volunteer this information. At the time of the examination this symptom made no impression upon us, but in retrospect we believe it may be a clue to the presence of regional ileitis. It is not at all inconceivable that the weight of an acutely inflamed and swollen bowel with its edematous gland-laden mesentery would cause traction on the root of the mesentery, which might very well account for the presence of backache.

Those cases which are more chronic in nature and simulate a partial intestinal obstruction or ulcerative colitis, and those presenting a chronic fecal fistula can probably be correctly diagnosed if the condition is kept in mind. If the clinician will cooperate with the roentgenologist and let him know what condition is suspected, serial x-ray studies of the gastro-intestinal tract may be of diagnostic value. Dr. Furst, the director of our x-ray department, reports that early in this disease local spasm and irritability are the only positive signs. At a later stage there may be distortion and narrowing of the affected bowel with a resultant stasis well beyond the normal period. As the disease progresses and the intestinal walls become infiltrated, the caliber of the lumen is further diminished, as a result of which the proximal loops of bowel may appear distended. If the mucosa is ulcerated the mucosal pattern becomes distorted or lost entirely. In the well-established case of long standing, the stenosis of the lumen may become so marked that the barium shows up as an irregular narrow stream—the string-like filling described by Kantor.

In those cases having symptoms of ulcerative colitis, sigmoidoscopic examination may be helpful. In ulcerative colitis the terminal portion of the large bowel is almost invariably involved; in fact, the disease most frequently originates at the distal end and progresses in a retrograde manner. In regional colitis or ileitis, however, the mucous membrane is normal as far as it can be seen through the sigmoidoscope. In one case, however, our procologist, Dr. A. L. Reich, reported that he had noticed scattered droplets of pus dripping into

the lumen of the sigmoid from above. These beads of pus did not originate in the sigmoid, because the underlying mucous membrane showed no inflammatory changes when the pus was sponged away.

A fecal fistula following an operation for suppurative appendicitis is not a rare occurrence, but most of these fistulae heal spontaneously. If one encounters a persistent fistula, or one which recurs after complete excision of the tract and suturing of the intestinal opening, the presence of a regional ileitis should be suspected.

If, after careful and thorough investigation of the patient, the diagnosis of regional ileitis or regional colitis is made, surgery probably offers the best hope for a good result. However, one of our patients, a young physician, has been treated medically and though he has had several stormy sieges he has remained well for almost two years, and is able to carry on an active practice.

The extent of the surgical procedure depends upon the findings at the operation. If the patient is acutely ill, and an abscess is encountered, it is much wiser to drain the abscess and perform no further surgery. If preoperative symptoms recur, or if a fistula results, the patient may then be prepared properly for a short-circuiting operation and a resection of the involved bowel. If this condition is discovered at the time of operation for a supposed acute appendicitis, some men advocate removing the appendix and closing the abdomen, because they believe that in about 30 per cent of these cases complete resolution may occur spontaneously. We treated two of our cases in this manner, but both of them required further surgery shortly thereafter. At the time of the short-circuiting operation it is most important to examine the entire bowel and mesentery, so as to be certain no distant areas of involvement have been overlooked. Despite this precaution, recurrences are seen. We are now treating a sixteen-year-old girl who developed an abdominal abscess one year after a resection of the terminal ileum and cecum. This abscess was drained, but healing did not follow and a persistently draining fistula resulted. This was shown to be connected with the intestinal tract

by the fact that the ingestion of carmine was followed by an elimination of the dye through the fistula. At this writing, the patient is being prepared for further surgery.

It may be of interest to report in detail the following case:

CASE REPORT

This young female, aged nineteen, first consulted us early in January, 1938. Her past history was essentially negative except for a voluntary loss of weight of thirty pounds two years ago, accomplished by means of an alternating banana and starvation diet. Her chief complaint was abdominal cramps occurring shortly after meals, occasionally accompanied by nausea. There was no history of abnormal bowel function. Examination was entirely negative except for slight tenderness over McBurney's point. We advised a gastro-intestinal x-ray, but our advice was not taken. For a short time thereafter she felt fairly comfortable, but in the early Spring the old symptoms recurred, occasionally accompanied by loose bowel movements. Again x-ray check-up was advised. A few days later the colicky pains became more severe and, because examination revealed more marked tenderness in the right lower quadrant, we admitted her to the hospital with a diagnosis of sub-acute appendicitis. At this time she volunteered the information that she had been troubled with a more or less persistent low backache, but we admit that we paid little attention to this complaint.

On April 6, 1938, under spinal anaesthesia, the abdomen was explored. The appendix was moderately congested, but examination of the ileum revealed the true cause of her illness. The terminal six inches of ileum was markedly thickened, the serosa congested and dull, and the subjacent mesentery edematous and studded with enlarged, soggy glands. No other portion of the bowel was apparently involved. The appendix was removed and one gland excised. Ileo-colostomy with exclusion of the diseased bowel was not done because the patient reacted poorly to the anaesthesia. The pathologic report was catarrhal appendicitis and hyperplastic lymph node.

She made an uneventful recovery and within three weeks returned to work as secretary in our operating room. About one month later she again became ill, but this time her complaints were not abdominal. She had backache and felt tired. Her ankles were swollen, her knees stiff and painful, and her fingers felt so thick that typing became difficult. She ran a low grade fever. We knew this girl had a definite regional ileitis, but since her present complaints were not gastro-intestinal, she was again hospitalized for a complete check-up. X-ray of the gastro-intestinal tract at this time showed involvement of the terminal ileum; and since all other laboratory procedures yielded negative results, we were forced to the conclusion that all her symptoms were the direct result of a toxic absorption from the diseased bowel.

A few weeks later, she again developed abdominal cramps accompanied by a mild diarrhea, and her temperature chart showed a daily rise to 101. She was seen in consultation by Dr. Crohn and he agreed with us that surgery was indicated.

At the second operation on September 21, 1938, we found the disease still localized to the terminal portion of ileum. The mesentery was markedly thickened but contained no visibly enlarged glands. An anastomosis was made between the transverse colon and the ileum, about six inches proximal to the involved area, with exclusion of the distal ileum. A portion of the ileum just proximal to the diseased area was excised for microscopic examination.

Her immediate post-operative reaction was good, but about one week later she began to show signs of peritonitis and she died on the fourteenth day. We were quite shocked at the outcome of this case because we felt our anastomosis had been well done. Permission for an autopsy was, therefore,

obtained and the following is our pathologist's report:

"The portion of the ileum attached to the cecum is thickened. The mucous membrane is congested and thrown up into longitudinal ridges with greyish depressed areas, giving the entire mucosa a rough, corrugated appearance. This process extends into the cecum and ascending colon. At the junction of the transverse colon and ileum, corresponding to the anastomotic area, the mucosa has a comparatively normal appearance and there is no evidence of leakage here. Beyond this, in the transverse colon and the major part of the descending colon, the process is extensive. The mucosa is granular, corrugated, ridged and ulcerated, so that all semblance to normal mucous membrane is gone. Several of these ulcerations have extended through the serosa opening directly into the peritoneal cavity. The fatal peritonitis was evidently due to these post-operative ulcerations distal to the anastomosis."

SURFACE ANESTHESIA FOR MUSCLE SPRAIN

By application of surface anesthesia, followed immediately by active motion, conditions of impaired function due to pain (as sprains and pulled muscles) can be so treated that immediate normal use of the affected part can be allowed in a majority of cases, Hans Kraus, M.D., reports in *The Journal of the American Medical Association*.

"The considerable shortening of the period of treatment and the early rehabilitation with restoration of normal function make it desirable that this treatment should find general application," Dr. Kraus says. "This is true especially in athletic injuries and injuries occurring to laborers and to those in the military service."

Regarding technic, the author says, "The direction in which the motion is impaired is first determined. Ethyl chloride is sprayed on this area of skin. The patient then starts careful active motion of the part involved, in the direction in which the motion has been painful and limited. As the patient carefully increases the movement, new painful areas—which up to this point have been hidden through blocked motion—will develop. Those areas again have to be sprayed and active motion continued."

"These treatments last from ten to thirty minutes. Immediately after the treatment, camphor liniment should be applied to the skin, to avoid frostbite."

"Patients should be advised to continue the active movements taught them—from twice a day to once every hour—for five minutes. While a single treatment will be sufficient in cases of minor involvement, patients with more severe involvement will have to be treated several times: the first week, daily—later, every other day."

"An effective treatment, however, should not call for the anesthetic after the second week, whereas active motion will have to continue until normal muscular power is restored."

"Immobilization after treatment is contrary to the basic principle."

Dr. Kraus considers the following groups of cases suitable for treatment by surface anesthesia and active motion, if major disturbance of the normal anatomy, such as fractures or a complete tearing of ligaments, muscles or tendons of the affected region are absent: (1) sprains of all joints; (2) acute muscular spasm due to lumbago, acute bursitis of the shoulder, pulled muscles, and (3) chronic muscular spasm due to "low back pain", sciatica, chronic osteoarthritis, shoulder spasm and the like.

Whenever treatment with ethyl chloride spray gives a negative result, it will be necessary to look for major changes in the anatomy. Thus this technic may be used as a means of evaluating diagnosis.

Excessive use of ethyl chloride spray may result in frostbite of the skin. To prevent this, camphor liniment or other counterirritants should always be used.

In acute attacks the effect of the treatment is amazing. Patients who have been disabled by acute sprains or acute muscular spasm often regain the full use of the affected parts immediately. Two to four treatments usually suffice to bring about, even in more serious cases, a minimum degree of discomfort. In all cases the period of disability is reduced drastically. Atrophy of the muscles involved does not develop to the same degree as when immobilization is employed. Swelling is more readily absorbed.

THE DOCTOR AS A PRESCRIPTION-WRITER

ADAM P. LEIGHTON, M.D., Portland, Maine

Dr. Leighton is Secretary of the Board of Registration in Medicine of the State of Maine. This paper is published at the request of the Committee on Pharmaceutical Problems of The Medical Society of New Jersey.

We certainly agree that the Doctor of Medicine who graduates today is a better man in theory, at least, than was he who came into the field shortly after the turn of the century. It is axiomatic, however, that the present-day graduate lacks much of the practical knowledge that was ours, especially in the administration of drugs and medicines as therapeutic agencies. When I graduated in medicine, we could write a prescription correctly in proper Latin form, and we knew that there was such a thing as a National Formulary and the Pharmacopoeia. That is more than I can say for the schools of today. Having received two years of real teaching in *Materia Medica* and a year of drilling in prescription writing, we were able to practice common sense medicine and make use of official preparations and products, which, after all, constitute the "stock-in-trade" of a Doctor of Medicine.

Two years ago the Maine Medical and the Maine Pharmaceutical Association commenced the exchange of delegates to their respective annual meetings. I have been privileged to be the medical delegate, and it has been a pleasure and a revelation to mingle with the druggists in scientific session. It is about time the medical and pharmaceutical brethren fraternized for consideration of the many professional matters with which we are so closely concerned. No two organizations in science are as closely allied as are the medical and pharmaceutical professions, and we can learn much that is reciprocally profitable by meeting regularly and discussing our common problems.

At one of these meetings, the Maine Commissioners of Pharmacy asked me: "What is the trouble with the young doctor today? He can't write a proper prescription! Why, even the osteopath writes a better one!" Another druggist stated to me that one young doctor, recently located in his town, came into his store and said: "I'll have to have your help. I really don't know how to write a prescription."

In the last five examinations given by the Maine Board I have set the questions in *Materia Medica* and Therapeutics. I am disgusted with the results! I want to give you the questions and comment upon the answers of the examination held in November, 1940. It was an "eye-opener" to me.

Question 1:

a. *Name eight official preparations of iron and give dosage.*

b. *Name six official preparations of mercury and give dosage.*

Of the eighteen men who took the examination only three were able to name two official preparations of iron, and in answer to the mercury question, two official preparations were the total number named. Curiously enough, the majority of the men gave Feosol Tablets, Hematinic Plastules and Frost's Ferroids as their answer. I don't doubt but that these are exceptional preparations, but whatever they are, they don't conform with my idea of what an official preparation might be. Nearly all did mention Bland's Pills. Of these eighteen men only one knew of Bashams Mixture, and he couldn't give its official name or its indication for use.

Only one man of the eighteen had heard of Monsel's Solution.

Question 2:

Write a prescription correctly and in Latin for a case of chronic bronchitis with cough, containing fluid extract of senega, fluid extract of squills, tincture of camphorated opium, syrup of tolu and water.

Not one man could do it correctly. Their attempts at Latin endings were pathetic, and they didn't even know the doses.

Question 3:

Write a prescription for La Grippe containing acetphenetidinum, quinine sulphate, camphor monobromate, caffeine citrate and codeine sulphate.

These prescriptions were likewise "abortions", for none was written correctly, and the Latin attempts were atrocious. Three of the applicants did not even attempt to answer the questions. One prescription written called for twelve capsules, and each one contained 18 grains. If this were dispensed each capsule would be about the size of an olive.

Question 4:

Write a prescription correctly and in Latin for rectal suppositories to be used in a case of acute cystitis in a woman with tenesmus and frequent urination, containing morphine or opium, extract of hyoscyamus, extract of belladonna, with a cocoa-butter base.

These "took the cake". One man indicated an amount of cocoa-butter which would have made each suppository at least the size of a Seckel pear, and would have demanded anal divulsion before the lady could insert it. Not one man wrote the prescription correctly. Most of them told me that they had never been shown how to write a prescription calling for the making of a suppository.

Question 5:

Write a prescription for a quarter of an ounce of a 25 per cent solution of argyrol to be used as a collyrium.

Only one applicant came anywhere near writing this correctly or indicating the proper amounts. One man gave as directions that it should be "rubbed on thoroughly", and, believe it or not, another gave it in teaspoonful doses. Only three men knew what a collyrium was. They could not figure the amount in grains added to two drams of distilled water—needed to give a 25 per cent solution. And we send these fellows out of medical school as qualified!

Question 6:

Give the rule for computation of the dose and state the amount of morphine that you would use hyperdermically after an appendectomy in a seven-year-old child. They all did fairly well on this.

Question 7:

Name the alkaloids or glucocides of physostigma, hyoscyamus, pilocarpus, belladonna, digitalis and opium and give the dosage.

This question, too, was answered with a fair degree of accuracy. The dosage was a little off,—some mentioned the dosage in minims and grains, but on the whole it was fairly well done.

The eighth question dealt with the diuretic action of certain drugs, and this, too, met with fair success.

The ninth question was *to treat a case of chronic cystitis with alkaline urine and pruritis vulvae*. The answers to this question were choice indeed. Only five men knew that with hexamethylenamine the urine must be acid, to obtain proper results. For pruritis vulvae, the remedial applications differed tremendously. One man applied unguentum hydrargyrum. You can imagine the result of such treatment! The lady would be relieved of her itching, but I believe other difficulties would surely ensue. Proprietary ointments were generally advised.

The tenth question was *to write a prescription for seborrhoeic eczema in the metric system, containing precipitated sulphur, salicylic acid, zinc sulphate, boric acid, glycerine and camphor water*. If the men had been taught the metric system in medical school, they showed no evidence of it. Their attempt at putting together this solution was a dismal failure. The amounts indicated were either too small or too large; one applicant advised rubbing it on the head, as if this was the usual or only possible location of the pathology. Another evidently thought that the end result of compounding would be an ointment.

Fifteen out of the eighteen applicants who took this examination did not attain the passing average. The next day, several of the men came to my office and their remarks were a little pathetic, to say the least. Each admitted that the examination was fair, but he "knew he hadn't passed it". They stated it was about what they expected, for they were not being taught Materia Medica and Therapeutics adequately or satisfactorily in their schools. One man said that certain members of his class had complained to the Dean of his institution about the teaching of these subjects, but to no avail.

Another reported that he had "never had more than a day or two of instruction in prescription writing". One other stated that his school had given him just two weeks of instruc-

tion in this subject, and that of a most cursory type.

What is the answer? I believe that medical schools, for the most part, are turning out "scientists", "theorists" and "medical nihilists". Do their teachers plan that they shall supplement their collegiate instruction by a post-graduate course given by the detail men or pharmaceutical representatives who haunt their offices after they start in practice?

This seems to be the present-day scheme. I have great respect for the qualified medical or pharmaceutical graduate who comes to me, detailing and demonstrating any real scientific medicinal product, and I am glad to greet him and give him heed. When it comes to the "sample and blotter" boys who undertake to teach us how to practice medicine, I say it is about time that we awoke and protested.

The medical profession has "put over" and made successful too many nostrums, patent medicines and low-grade proprietaries, as is evinced by the casual observation of the advertisements in the windows of almost any cut-rate perfumer's shop or department store, as well as of the cut-rate drug store.

I had occasion recently to look over a druggist's prescription file. I counted 51 so-called prescriptions before I came across one that was written correctly or scientifically, which called for official drugs and medicines. There are

many excellent proprietary preparations on the market; most of them have a short, catchy, or coined name, which makes it easy for the laity to read on a prescription and remember. No wonder that "counter-prescribing" is on the increase and no wonder, too, that the patient passes the name of the medicine about the neighborhood and among his friends as being recommended and prescribed by his doctor.

The members of the medical profession are, and have been, very short-sighted. In these latter years they have been wont to cast aside their knowledge of *Materia Medica* and to write prescriptions too generally and promiscuously for the myriad of proprietary pharmaceutical preparations which are detailed to us every day.

The medical student should have it emphatically stated to him that *Materia Medica* is still being taught and that it is one of the most important subjects of the medical school curriculum. He should be given a course of adequate instruction during his medical study which would guarantee that he was properly schooled in his *Materia Medica*, which is, after all, "the backbone of medicine".

Editor's Note: This seems to us a very challenging paper. Is the situation as bad as Dr. Leighton suggests? Or is he too pessimistic? The Journal welcomes communications from members on this subject.

261 Western Promenade

FOOD POISONING

"Ptomaine poisoning doesn't exist!" At least, that's what Dorothy V. Whipple, M.D., said in a recent issue of *Hygeia*. She points out that illness caused by eating unwholesome food is not due to the presence of ptomaines, and should more accurately be termed food poisoning than ptomaine poisoning.

"Ptomaine is a word for substances which form in decomposing foods. Many different compounds come under the general term ptomaines, but they all have in common the property of being made by bacteria out of decomposing protein. * * * However—unbelievable as it may seem—the ptomaines in such food, even when the food is eaten in large quantities produce no ill effects in the human body."

The most frequent source of food poisoning,

according to the author, is the growth of bacteria in food. She says. "Occasionally bacteria producing disease are introduced into food. Many bacteria find food a suitable place in which to grow, so that a few organisms accidentally dropped into food may become many thousands by the time the food is eaten. The germs which cause food poisoning or food infection belong to two types. One is the salmonella group. The other, the staphylococcus group, is most frequently found in milk products.

Dr. Whipple says that food handled a great deal is more apt to be harmful than food eaten without such handling, but she adds, "If infected food is thoroughly cooked, all harmful bacteria will be killed and the food can be eaten with impunity."

CONGENITAL DEXTROCARDIA WITH OR WITHOUT SITUS INVERSUS VISCERUM*

By MAX GROSS, M.D., Atlantic City, N. J.

Cases of dextrocardia, with or without visceral transposition, have been recorded in the literature for many years. Clinicians have undoubtedly seen many more cases than those reported, since subjects presenting such developmental anomalies seldom have subjective complaints.

The x-ray and electrocardiogram have been a boon in the study of such cases. Through these instruments many cases have been seen and studied that would have escaped routine observation. Many more are observed routinely as result of mass x-ray for the study of chest cases.

FREQUENCY

No definite estimate of the number of such cases occurring in a given population is possible. Some authors estimate that situs inversus viscerum occurs in the ratio of one to eight or ten thousand people. Isolated congenital dextrocardia is indeed very rare. At our Sanatorium, each year approximately 10,000 patients are examined by our staff and roaming clinics, and at least 80 per cent of these have roentgenograms. During the past eight years not a single case of dextrocardia has been seen. However, within a period of one year, four cases were observed. As a matter of fact, three cases were admitted within a short period of each other. With the recent demand for mass x-ray to discover early tuberculosis, many of these anomalies may be seen. Perhaps, within a few years of such intensive x-ray studies throughout the United States, some accurate estimate of the frequency may be possible.

TYPES

Classification of these anomalies is still confused. Commonest anomaly is congenital dextrocardia with situs inversus viscerum. This is also called *heterotaxia* and *situs viscerum totalis*. The rarer form is isolated congenital dextrocardia. Most agree with Roesler¹ that

an effective classification must be based on roentgenographic, electrocardiographic, and anatomic findings.

In true congenital dextrocardia, the ventricles are displaced. On the right is the bicuspid valve, on the left the tricuspid, while the auricles are normally aligned with the aorta, the latter being on the left, anterior to the pulmonary artery. The cardiac apex is formed by the left ventricle and is directed to the right. In none of the reported postmortems was there actual transposition of all parts of the heart and blood vessels in association with isolated congenital dextrocardia. On the other hand, the vessels may be found in a corrected position, i. e., an abnormal course, but a normal entrance into the corresponding ventricles; or a normal course and a normal emptying.

When the auricles are in a corrected position, the electrocardiogram may show the upright position of the P. R. T. waves. If, on the other hand, the ventricles as well as the auricles are transposed, the P. R. T. waves will be inverted. Inversion of all the complexes in L₁ are taken as an indication of congenital dextrocardia as differentiated from dextrocardia cordis (acquired dextrocardia).

According to an exhaustive study by Moffet and Neuhoof² and Moffet,³ only 126 cases of isolated dextrocardia had been reported from 1649 to 1915. Lichtman⁴ reports that up to 1931, 161 cases have been found in the literature. Most of these occur in the male and present severe anomalies.⁵ It is surprising that about 21 per cent of the cases studied by Roesler¹ showed congenital defects in both congenital dextrocardia and situs inversus viscerum totalis.

Congenital dextrocardia must be differentiated from the type in which there is found displacement of the apex to the right and base toward the left. Here, the arrangements of the auricles and ventricles are normal. The P. R. T. waves are in the upright position. This condition is known as *dextroversion*.

* From the Medical Service of the New Jersey State Sanatorium, Dr. S. B. English, Medical Director.

ACQUIRED DEXTROCARDIA

Acquired dextrocardia must be distinguished from the congenital isolated type. The acquired form occurs in pulmonary tuberculosis. Tumors, aneurysms, effusions, congenital eventration, pneumothorax, etc., displace the heart toward the *healthy* side. However, far advanced pulmonary tuberculosis will displace the heart toward the *affected* side. Such cases are relatively rare, but smaller displacements and rotations are commonly observed.

The mechanism involved in displacing the heart in pulmonary tuberculosis was excellently discussed by Fishberg.⁶ The heart is strongly fixed to the mediastinum by its anatomic attachments to the deep cervical fascia above, tendinous attachments to the diaphragm below and posteriorly by ligaments to the sternum. Hence, pulling the heart in any direction is not an easy matter. The region of the great vessels, trachea, and oesophagus,—i. e., the superior mediastinum—is the zone in which displacement most often occurs. In that area one usually sees displacements during the course of artificial pneumothorax, tumors, and other related pathologic conditions.

Fibrosis, cavitation, atelectasis and retraction drag the heart out of its normal place and into the affected area. In advanced tuberculosis involving the right pulmonary field, showing the above changes, the heart will be displaced to the right—at times, completely so. (Fig. 1.) Such a case may often lead to confusion until an electrocardiogram may be the only differential factor. However, the trachea and the mediastinal structures are usually pulled along with the heart to the right.

In the normal heart, the cardiac apex is more anterior than the base. In many cases of pulmonary tuberculosis the heart is not only displaced, but it is also rotated on its axis. Traction occurring on the right side of the mediastinum brings the base of the heart more anterior than the apex. The elevated diaphragm in the right hemithorax also plays an important rôle in dislocating the heart; and together with the pleuro-pericardial adhesions, may change the heart in any manner conceivable.

Congenital dextrocardia with situs inversus viscerum is the commonest anomaly observed.



FIGURE 1.

Acquired dextrocardia due to fibrosis and atelectasis from a case of a chronic, far-advanced pulmonary tuberculosis. Note the extreme rotation and pulling over, toward the right, of the heart, mediastinal structures, trachea and bronchi. There is some myocardial damage due to increased pulmonary tension.

In this condition, in addition to the heart being on the right side with the apex lying to the right, the axis is directed from the left above, downward to the right, the mediastinum in the midline; the abdominal organs are also transposed. The left diaphragm is more elevated than the right, the liver on the left; spleen and stomach on the right; the large bowel transposed and the appendix on the left.

Rush and Rush⁷ reported 319 cases up to 1928. Probably another hundred or more have been reported since by other authors. X-ray shows a mirror image of the heart and abdominal organs, while the electrocardiogram shows the inverted first lead, with normal second and third leads.

Anomalies of individual organs have also been observed.^{8,9} Cases of inverted position of the viscera with anomalies of the genital organs have been reported by Lichtman,⁴ Tecce¹⁰ and others. Any type or any combination of

anomalies may occur in congenital dextrocardia, with or without the transposition of the organs.

CAUSES OF ANOMALIES

Most authors explain the anomalies in terms of developmental defect. None of the theories is applicable to all the anomalies observed.

Dessylla and Monticelli¹¹ believe that situs inversus viscerum is due to a total or partial inversion of polarity. This takes place during ovulation or maturation of the ovum, or at the latest during the period of fertilization.

Pezzi and Carugati¹² quote Geoffray St. Hilaire's theory that the liver determines the localization and the lateral relationship of the other organs. Thus, if the liver is on the left, the other organs must of necessity assume their position on the right. They further quote Daresti and Rindfleisch, who believe that the heterotaxia depends on the starting position of the heart. But these theories, say Pezzi and Carugati, mistake effect for cause. They call attention to the hypothesis of Martinotti and that of Lochte which holds that cardiovisceral transposition is the consequence of an abnormal situation of the embryo on the umbilical vesicle. This causes an inversion of the viscera in the splanchnic cavities. These ideas seem to agree with Baer's hypothesis that, if the rotation of the body around its axis begins on the opposite side than the normal, and the embryo on the right side, then the organs must occupy the left side.

Willius¹³ advances Bryce's theory, in that the two primitive cardiac tubes fuse into one on about the fifteenth day, and an auricular-ventricular, bulbar subdivision becomes apparent. The tube becomes bent on itself and determines largely the future axis of the heart. In congenital transposition, the primitive tube bends into a contrasigmoid instead of a normal sigmoid manner. It is then assumed that the embryo lies in an abnormal position within the chorion, so that the right, instead of the left, side lies closer to the blood supply.

In attempting to explain isolated congenital dextrocardial, Moffet and Neuhof² suggest that in the embryo the right side of the heart

develops faster than the left, and consequently pulls the heart to that side. This may be applicable to acquired dextrocardia occurring during fetal life, but does not seem to explain the true mirror image of the heart.

Pulmonary tuberculosis in congenital dextrocardia with or without visceral transposition, is indeed rare. No one can evaluate actual frequency of tuberculosis in association with the anomalies described. The literature on this is meager. Some tuberculosis authorities who have had wide and long experience are unable to recall any cases. Bernard and Lamy¹⁴ report a case of congenital dextrocardia and bronchiectasis, believed to be tuberculous in origin. Reisman¹⁵ in a routine study of tuberculosis in children, reports eight cases, but none showed evidence of pulmonary tuberculosis. Lichtman⁴ mentions a few cases of pulmonary tuberculosis.

In the case reports to follow mention will be made only of the pertinent facts.

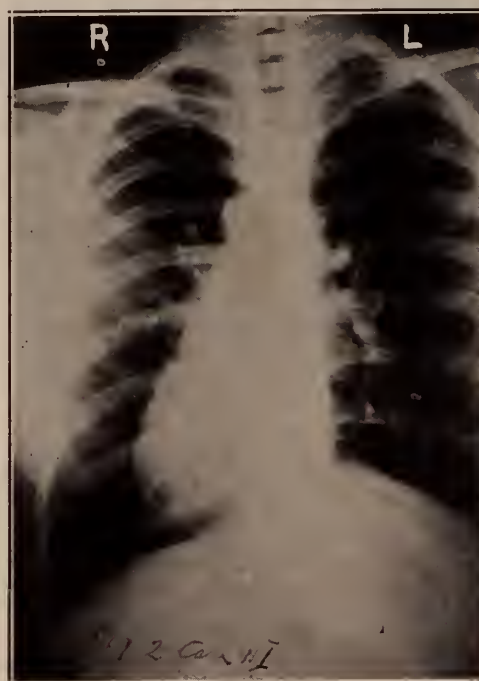


FIGURE II.

Case 1. Isolated congenital dextrocardia without visceral transposition. Note heart situated on the right side. Liver is on the right and gastric air bubble on the left. The diaphragm on the left is higher than on the right.

CASE 1

Mrs. H. H. W., 28 years of age, white, a graduate nurse, asked to be examined because of a routine positive tuberculin test. There was no family history of tuberculosis. At the age of 12 and 14 years, several tuberculous cervical glands were incised. At 16, while being examined for insurance, she was told that her heart was on the "wrong side and to be careful if she ever developed pain in the left lower abdomen as it may be appendicitis". While in training, she developed diphtheria, and was confined to bed for three weeks. She felt well at the time

and was very active without evidence of dyspnoea.

On examination, her heart was found to be transposed. There was no evidence of cardiac damage and the lungs were clear. X-ray of Chest (Fig. II) revealed a dextrocardia; no lung disease was found. The liver and the stomach occupied the normal position. The left hemidiaphragm was elevated. Gastro-intestinal x-ray (Fig. III) showed that the abdominal organs were not transposed. An E. K. G. (Fig. IV A) showed the first lead to be inverted with normal L_2 and L_3 .



FIGURE III.

Case 1. G. I. series shows the stomach on the left side. The appendix was in its normal right position in another film.

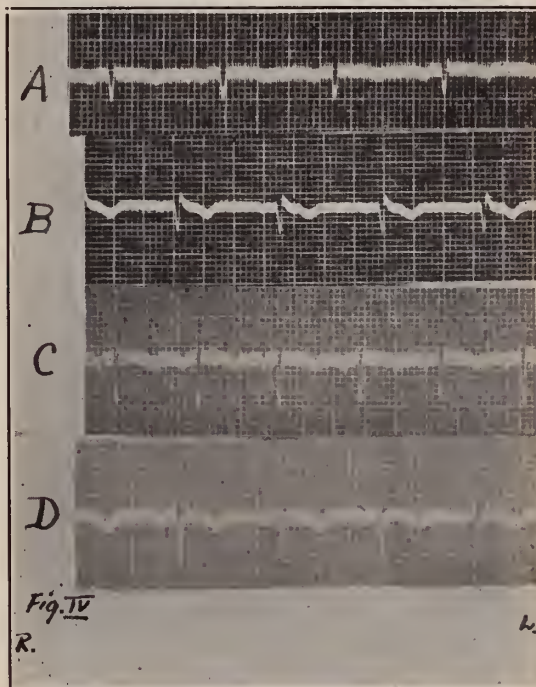


FIGURE IV.

Electrocardiograms of the four patients demonstrating the inversion of lead one in each case. Leads two and three were normal. No evidence of any heart disease.

CASE 2

M. A., a Portuguese male, aged 13 years, was admitted on October 7, 1935, with a history of cough, expectoration and loss in weight. He had not felt well since a tonsillectomy under general anesthesia five months before. Severe cough followed within one week after tonsillectomy and expectoration increased to about an ounce daily; it was greenish in color, but odorless.

On examination the chest was found to be fairly symmetrical with limited expansion on the left. Tactile fremitus was increased in the left lower half with moderate dullness along the lower two-thirds. Fine and medium course râles were heard along that area, both anteriorly and posteriorly.

Scattered sibilant râles were audible in the same area.

The heart was found to be located on the right, with the apex beat in the fifth right costal border, about three inches from the sternal border. The heart was found to be normal. Liver dullness was on the left and the stomach on the right.

A roentgenogram of the chest (Fig. V) revealed the dextrocardia. The left lung showed pathologic density along the hilar and cardiac border extending from the second to the fifth ribs. The left diaphragm was elevated, and the liver shadow was on the left and stomach air bubble on the right. Gastro-intestinal series (Fig. VII) revealed com-

plete transposition of the abdominal organs. An E. K. G. (Fig. IV B) proved the case to be of congenital origin with inversion of all the complexes in L_1 .

He received routine dietetic-hygienic care and bed rest. His condition improved rapidly, and within two months the cough and expectoration completely disappeared. Subsequent x-ray studies showed the gradual absorption of the lung disease.

A recent follow-up (Fig. VI) showed him to be in excellent health with his pulmonary disorder healed.

Repeated sputa studies failed to demonstrate tubercle bacilli. Mantoux test was 3 plus. It was felt that his lung involvement was not tuberculous in nature. In view of the history of tonsillectomy, the case was classed as pneumonitis.

There was no evidence of lung abscess. The diagnosis on discharge was congenital dextrocardia with situs inversus viscerum and left pneumonitis.

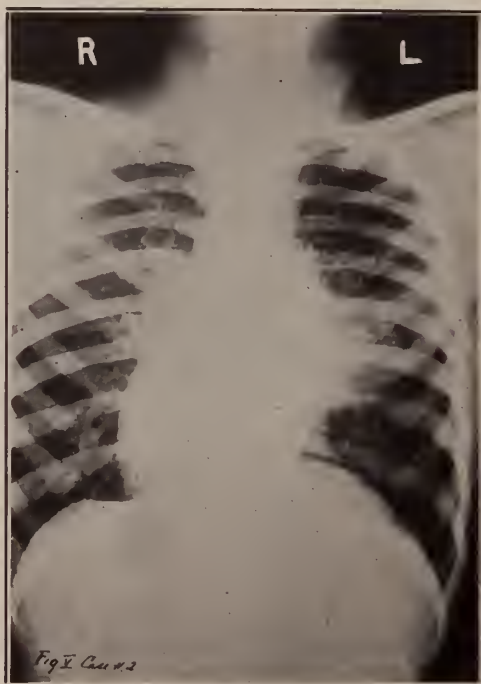


FIGURE V.

Case 2. Congenital dextrocardia with situs inversus viscerum. Note the heart and stomach air bubble on the right, and liver on the left. Pathologic density is seen in the left mid-portion of the lung, between the third and fifth ribs. The diaphragm is elevated on the left. No evidence of definite lung abscess is noted.



FIGURE VI.

Case 2. The pneumonitis on the left disappeared completely in 8 months. No reappearance of the pathologic involvement was seen in x-ray taken four years later, but there was definite fibrosis along the area originally occupied by the disease process.

CASE 3

Mrs. J. L., white, 25 years old, admitted October 14, 1937, with a history of cough and expectoration of a cupful of greenish sputum for the past year. In December, 1936, she had a hemoptysis of several ounces with streaking for several days. Other symptoms were intermittent pain on the right side of chest, fatigue, loss of 12 pounds in a year, palpitation and irregular menstruation. She had been suffering from sinusitis ever since childhood. In 1933, she developed pneumonia of the left lower lobe followed by empyema and later rib resection.

Physical findings were: Impaired resonance at both lower lobes with fine, medium, coarse, and

bubbling râles throughout both lower lobes. The signs were more pronounced on the right lower lobe. The heart sounds were more evident on the right, apex beat in the fifth interspace with greatest intensity about four inches from the right sternal border. Rate and rhythm were normal, and the sounds were of good quality with no murmurs. The liver was on the left and stomach on the right.

X-ray of the chest (Fig. VIII) revealed the dextrocardia, and further disclosed some atelectasis of the right lower lobe with scattered exudative infiltrations involving part of the lower portion of the upper lobe and all of the lower lobe. There were

definite peri-bronchial thickenings. The left lower lobe showed increased perivascular and peribronchial thickenings. The left hemidiaphragm was elevated. The liver shadow was on the left and stomach on the right. Gastro-intestinal series showed complete transposition of all abdominal organs. Skull x-ray disclosed frontal and maxillary sinusitis. An E.K.G. (Fig. IV C) proved the case to be of a congenital origin, as evidenced by the inverted P.R.T. complexes in L_1 .

Careful and repeated sputa studies were negative for tubercle bacilli. Lipiodol instillation was unsuccessful due to the chronic nasopharyngitis and ex-

treme nervousness of the patient. Mantoux test was negative to all dilutions. Sedimentation rate was markedly elevated. Wassermann and urinalysis were negative.

After a period of Sanatorium regime the patient improved, with decrease in cough and expectoration. She gained 20 pounds and was discharged February 23, 1938. Diagnosis on discharge was congenital dextrocardia with situs inversus viscerum, bilateral bronchiectasis, chronic sinusitis and chronic nasopharyngitis. It is interesting to note that this subject's sister was also a patient at the Sanatorium with moderately advanced tuberculosis but no evidence of any congenital anomalies.



FIGURE VII.

Case 2. G. I. series demonstrated complete transposition of the gastro-intestinal tract. The stomach was on the right. Barium enema showed the presence of situs inversus viscerum. The appendix could not be demonstrated.

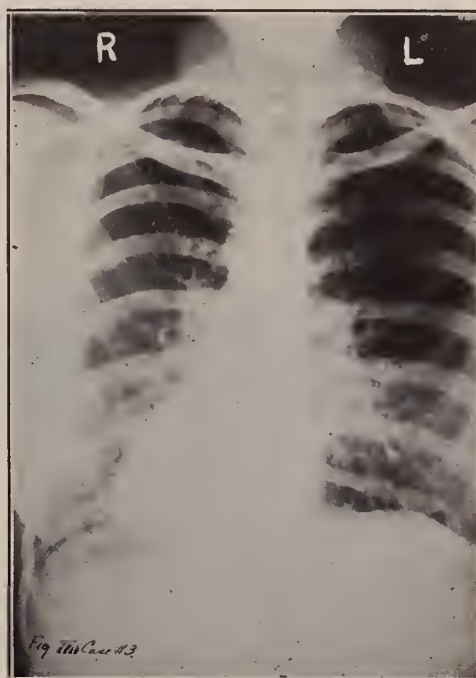


FIGURE VIII.

Case 3. Congenital dextrocardia with situs inversus viscerum. Heart is on the right. Liver is on the left with diaphragm elevated and stomach on the right. There are marked bronchiectatic changes on the right with lesser involvement on the left base. The tenth left rib had been resected. A gastro-intestinal series with a barium meal demonstrated the situs inversus of the abdominal organs.

CASE 4

Miss H. I., white, 21 years of age, a student nurse, admitted November 8, 1937. In March, 1937, she suffered whooping cough, followed by pneumonia on the right side. After recovery, she developed a streptococcic sore throat. She felt well until October 8, 1937, when she suddenly coughed up an ounce of bright red blood. X-ray revealed a small density on the left second interspace. She remained in bed until admission to the Sanatorium. On ad-

mission, all her symptoms had disappeared with the exception of an intermittent aching in the upper left chest. She had gained 20 pounds before admission.

Physical findings were—a questionable increase in tactile fremitus on the left upper, and no râles. The heart was found to be mainly on the right with the apex beat in the fifth interspace about three and one-half inches from the right sternal border.

No abnormalities were evident in the heart. The liver shadow was on the left and the stomach on the right.

X-ray of the chest (Fig. IX) revealed the dextrocardia. In the area of the second interspace on the left was a receding exudative density, much less than on her original roentgenogram taken October, 1937. The left hemidiaphragm was elevated with the liver shadow beneath, and the stomach air bubble on the right. Gastro-intestinal x-ray revealed complete visceral transposition; and an E. K. G. (Fig. IV D) proved the case to be of congenital origin.

Repeated sputa studies failed to reveal tubercle bacilli. Mantoux test was 3 plus on higher dilution.

On routine sanatorium care she improved and the pathologic lesion disappeared on the left. She was discharged with a diagnosis of congenital dextrocardia with visceral transposition and pneumonitis. A recent follow-up shows that the patient is in excellent health, has graduated, and is doing public health nursing.



FIGURE IX.

Case 4. Roentgenogram shows heart on the right side, liver on the left with the diaphragm elevated, and the stomach air bubble on the right side. Along the second left anterior interspace, in the mid-zone is a fibrosing lesion. In the plate taken several weeks ago was a definite density about the size of a half-dollar in the same area. A barium meal revealed the situs inversus viscerum.

DISCUSSION

The literature is replete with descriptions of the anomalies in congenital dextrocardia, with or without situs inversus viscerum. Isolated organ displacements and anomalies have also been described. A discussion of the controversial aspects of this subject may be found in the exhaustive studies of Roesler¹ and Lichtman.⁴

There has been much speculation about the rise of the diaphragm. In congenital dextrocardia with situs inversus viscerum, the left hemidiaphragm has been found to be elevated. Some authorities believe that the rise is associated with the localization of the liver. Thus, if the liver is on the left, the left hemidiaphragm is elevated and vice versa. However, in isolated congenital dextrocardia the left leaf of the diaphragm is also elevated, even though the liver is on the right. Hence, the assertion is made that the localization of the heart is responsible for the rise of the diaphragm. If the heart is on the right, the left leaf of the diaphragm is elevated and vice versa. Excluding an anomalous formation of the phrenic nerves, both the heart and liver probably play some rôle in the elevation of the hemidiaphragm.

Another interesting factor is the occurrence of bronchiectasis in these cases. This disease, alone or associated, with sinusitis cannot be considered coincidental. We have here a triad of situs inversus, bronchiectasis and sinusitis (Kartagener syndrome). It is probable that bronchiectasis precedes the sinus infection and that the former is congenital in origin.¹⁶ Other authorities believe that bronchiectasis generally follows a chronic sinusitis during a prolonged period of a sinus infection. It is, therefore, conceivable that such a course can follow in the cases of situs inversus viscerum. If a history of bronchiectasis is obtained in early infancy, the cause is, most likely, congenital; it may be a stigma of maldevelopment. Our Case No. 3 probably fits into this latter category.

The paucity of case reports of pulmonary tuberculosis associated with congenital dextrocardia and situs inversus is obvious. This may

be purely accidental. We have not seen the two conditions at our Sanatorium. Other institutions may have seen them; but they have not been reported. The four cases reported in this paper failed to show any pulmonary tuberculosis. Three had definite non-tuberculous pulmonary disease and were proved cases of congenital dextrocardia with situs inversus viscerum. Two of these had an associated pneumonitis which completely absorbed on bed rest.

109 States Avenue

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STENOGRAPHY AS A HAZARDOUS OCCUPATION

Office work that involves constant abduction of the arms for months and years may be a causative factor in subacromial bursitis with calcium deposition. So thinks Boardman M. Bosworth, M.D., who reported in a recent issue of the *J. A. M. A.* that routine examinations disclosed calcium deposits in the tendons of the shoulder-joint muscles of almost 3 per cent of office workers. "Women typists," finds Dr. Bosworth, "had a significantly higher incidence of deposits than women clerks."

"Therefore, while it cannot be proved that any particular job was responsible for a certain calcium deposit, nevertheless occupation as a causative factor must be given due consideration in deciding whether the work in question produced or helped to produce the deposit,

when that work involves constant abduction of the arms.

"Best treatment for the acute attack is prompt excision of the deposit. In experienced hands it is a minor procedure, done through a small incision. It gives immediate, certain and complete relief which has been permanent. The patients have had an average hospital stay of four days and have been able to resume their usual duties, with unrestricted shoulder motion, in three weeks. * * *

"The application of heat is therapeutically sound, but as an adjuvant rather than as a basic form of treatment. I use it following operation to speed healing and recovery. * * *

"Immobilization of the shoulder by swathe or by plaster is mentioned to be condemned, because of the danger of adhesions."

PNEUMONIA — THE NEW PHASE

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Since the dawn of history, pneumonia must have reaped a huge harvest of the lives of men. The symptoms of the disease were well described by Aretaeus, during the age of Hippocrates of Greece.

In the 17th century, William Cullen, of Edinburgh, in his botanical classification of diseases, described "fever" in Latin, which apparently had been taken from his observation upon pneumonia. His translation reads that "after a rigor, a quick pulse, high temperature, many body functions depressed, the strength especially of the joints diminished". What better picture could we have of pneumonia as we know it today?

Osler, speaking of pneumonia, said, "It has become the captain of the men of death, to use John Bunyan's term for consumption." He described the disease as he knew it, as "self-limited disease which can neither be abated, nor cut short by any known means at our command".

FALLING MORTALITY

Pneumonia has always ranked high in the mortality records of the country. There has been during the last 75 years a considerable reduction in deaths from this cause throughout the country. In 1917, there were in the registration area 112,821 deaths from pneumonia making a rate of 148.8 per 100,000 population. In 1938, 20 years later, this death rate had been reduced to 67.5 per 100,000, a reduction of 54.7 per cent. This was the lowest rate ever recorded from pneumonia since the registration area was established in 1900.

The 1938 rate showed a decline of 20 per cent as compared with that of the previous year.¹ This reduction in the pre-serum era can perhaps be explained by the improved economic condition of the people, together with greater care in the preservation of health in the home and in industry. Associated with this decrease

must also be considered the diminished frequency of epidemic diseases which are known to be frequently followed by pneumonia.

THE ERA OF ACTIVE TREATMENT

Within the last ten years there has come a dramatic change in the attitude of physicians to pneumonia. Formerly the treatment of the pneumonia syndrome was a compound of watchful waiting and hopeful praying, that the former life and habits of the patient had not undermined his physical ability to withstand the shock of one of the greatest killers: the pneumococcus.

With the exception of the oxygen tent, treatment had been limited to helping the patient through his crisis, by cardiac therapy and dietary sustenance. This with careful bedside nursing was the limit of medical assistance that could be rendered at a time when every available resource the patient possessed was eventually called upon.

No specific drug or therapy was available for the treatment of pneumonia until the introduction of serum by Cole² in 1912. The development of antitoxic serum proceeded slowly in spite of the fact that Augustus Wadsworth, of New York, had in the early years of the century shown that rabbits could be immunized against the pneumococcus and that the normal susceptibility of rabbits to a generalized septicemia could be changed to a localized infection similar to that found in man. It was Wadsworth's contention that the localization of the pneumonia lesion in the lung in man was due to a gradual immunizing of the human body to the pneumococcus, as the result of years of previous infections with the disease. It was thus evident that the future had considerable promise of successful treatment of pneumonia by antitoxic serum. The observation of Wadsworth was subsequently verified by the brilliant work of Felton³ with concentrated anti-

toxic serum in 1924, and later by Cecil and Plummer.⁴ These latter observers, using Felton's serum in 1932, reported⁵ that with serum for Type 2 cases in 21 patients, the death rate was 14.3 per cent as compared with a death rate of 45.8 per cent for untreated cases.

NEWARK RESULTS PROMISING

In 1931-1932 a supply of Felton's concentrated serum for Types 1 and 2 cases was made available in the Newark City Hospital. Typing facilities were not generally used for patients under serum treatment. Very encouraging results were obtained. Thirty-eight cases of Types 1 and 2 treated with Felton's serum showed a mortality of 10.5 per cent. Among a general group of 121 untyped cases, mortality rate was 31.4 per cent. This included⁶ lobar and broncho pneumonia. Cecil and Plummer⁴ reported a death rate in untreated pneumonia of 45.8 per cent at that time. The information gained by this study stimulated State Departments to carry on pneumonia work and to ask governments for funds to provide or produce free antitoxin serum. Progress in serum therapy had followed very rapidly upon the earlier attempts at treatment with antitoxic pneumonia serum.

Georgia Cooper⁷ of the New York Health Department reported in 1935 that she had found 32 distinct types of the pneumococcus by means of the Quelling reaction, each of which could be neutralized only by the special anti-serum developed for each type. Thus the problem of successful treatment was further complicated. It was evident that logical desiderata for serum treatment for pneumonia were (1) a rapid typing system that could be used for laboratory diagnosis and (2) the commercial development of antitoxic serum for each of the 32 types of the pneumococcus.

Rapid typing was found in the Neufeld method, which showed that the capsule of the pneumococcus of each type was enlarged in the presence of the special antitoxic serum. The test was so easily done that it could be carried out by the simplest laboratory procedures.

Serum for Types 1, 2, 5, 7 and 8 of the pneumococcus was eventually made in enor-

mous quantities from the horse; later a rabbit serum was made available. These types of pneumonia were found most commonly in the East.

The impetus for widespread serum therapy was really furnished by the Massachusetts Pneumonia Study⁸ of 1931-1935. State departments of health began buying or making their own pneumonia serum.

NEW JERSEY PROGRESS

In 1938, the N. J. State Department of Health by a State appropriation was able to buy large quantities of serum for Types 1, 2, 5, 7 and 8 for free distribution through the medical profession. Typing stations were established throughout the State.

The Newark Health Department became the leading serum distributors for local and county needs. It was demonstrated that early use of antitoxic serum would reduce the mortality rate from pneumonia by about 50 per cent. The typing of the case as advocated by Bullowa and his associates was stressed and a 24-hour typing service was established in the City Laboratory.

At the same time, a pneumonia bureau was established in the Health Department to bring about special contact with the physicians and hospitals. The functions of this bureau were to supervise serum distribution and to arrange for the quick transportation of sputum specimens to the laboratory and serum to physicians.

Contacts were established with the various hospitals to encourage typing of all cases. It was the function of this bureau also to secure speakers upon pneumonia for public meetings and for hospital groups and to arrange for the exhibit of a special pneumonia film. The physicians of the city were circularized and notified of the facilities for rapid typing and for serum distribution.

MORTALITY REDUCTION IN NEWARK

Effects of the serum treatment of pneumonia soon became apparent. Table 1 gives a comparison of deaths and fatality rates for 1938 and 1939 for Newark as compared with 1937 when the organized pneumonia campaign was begun.

TABLE 1

Year	Cases	Deaths	Fatality Rate	Treatment
1937	2138	429	20 %	No organized Pneumonia Campaign.
1938	1604	312	19.5%	Six months' use of serum alone.
1939	1731	231	13.3%	Full year of serum and sulfapyridine.
1940	1577	194	12.3%	Sulfapyridine plus serum in 126 cases. Sulfapyridine alone in 1033 cases. Sulfathiazole alone in 86 cases. Serum alone in 13 cases.

The lower mortality in 1938 was ascribed to the fact that the physician had been made very pneumonia conscious. Earlier diagnoses were being made because the physician knew that serum treatment would greatly reduce mortality. At the same time, the already high proportion of case reporting was increased. Further impetus was furnished when a biological house supplied rabbit serum for all 32 of the pneumococcus types. The use of rabbit serum reduced considerably the possibility of anaphylactic reaction which frequently had complicated and reacted against the use of the horse antitoxic serum.

SULFAPYRIDINE

In July, 1938, Evans and Gaisford,⁹ reported the use of a new drug, sulfapyridine, which when taken orally in pneumonia acted in the same manner as did serum when given intravenously. In addition, this drug was efficacious for all 32 types of pneumonia and was inexpensive. Their results showed a fatality rate of 8 per cent in a series of 100 sulfapyridine treatment cases.

The medical profession was warned that this new drug in unregulated and excessive doses produced severe anemia, hematuria and kidney calculi. Other investigators quickly began using sulfapyridine—generally with very satisfactory results. Another advantage of sulfapyridine was that children with pneumonia tolerated the drug well. Further experience showed that in patients seriously ill with pneumonia the treatment might well include both serum and sulfapyridine. The program of the Newark Health Department therefore revolved about the use of both agents. This was made easier inasmuch as Newark had for free distribution most of the 32 types of anti-sera, many of them produced from rabbits.

By 1939, after a full year of serum and

sulfapyridine, the fatality rate for all cases in the city had dropped to 13.3 per cent. In 1940, this rate was further lowered to 12.3 per cent. This was the lowest case fatality from pneumonia ever recorded in the history of the city.

EARLIER DIAGNOSIS IMPORTANT

An encouraging aspect of the publicity given to the public by the campaign of the Newark Health Department is that physicians are being called to see pneumonia cases much earlier in the disease than formerly. Hospital records also indicate that the proportion of early cases of pneumonia admitted is greater than before. Exhibit of the pneumonia film "New Day" in the theatres of the city, the newspaper publicity given to pneumonia during the vigorous serum campaign of 1939, the introduction of sulfapyridine, the bill-board space donated for pneumonia during this year, and circulars outlining the early signs of symptoms of pneumonia, have shown dividends for health in reducing the mortality from this great killer among diseases of the chest. The public is becoming increasingly "pneumonia conscious".

TABLE 2

No. Cases	Medication	Case Fatality Rate
1033	Sulfapyridine	7.4%
302	Neither serum, sulfapyridine or derivatives	29.4%
126	Sulfapyridine plus serum	11.1%
86	Sulfathiazole only	7 %
13	Serum only	7.1%
8	Sulfathiazole plus serum	25 %
4	Sulfanilamide only	none
2	Sulfathiazole plus serum and sulfapyridine	none
1	Sulfanilamide plus serum	none
1	Sulfanilamide plus sulfapyridine	100 %

STATISTICAL EVIDENCE

In 1937, pneumonia was third in the number of recorded deaths in Newark, being exceeded only by heart disease and cancer. In 1939, the

TABLE III.
PNEUMONIA RECORD—1940—AGE PER TREATMENT

	Under 1 Year	Over 1 Yr. and Under 5 Yrs.	Over 5 Yrs. and Under 15 Yrs.	Over 15 Yrs. and Under 25 Yrs.	Over 25 Yrs. and Under 45 Yrs.	Over 45 Yrs. and Under 65 Yrs.	Over 65 Yrs.	TOTAL CASES	TOTAL DEATHS	TOTAL FATALITY RATE
Serum Cases Only .....	..	1	1	1	4	6	..	13	1	7.7%
Serum Case Deaths .....	..	..	..	..	..	1	..	..	..	..
<i>Serum Fatality Rate</i> .....	..	..	..	..	..	16.7%	..	..	..	..
Sulfapyridine Cases Only	85	158	116	87	213	247	127	1033	80	7.4%
Sulfapyridine Case Deaths	8	1	3	1	13	26	28	..	..	..
<i>Sulfapyridine Fatality Rate</i>	9.4%	0.6%	2.6%	1.1%	6.1%	10.5%	22%	..	..	..
Sulfapyridine Plus Serum Cases Only	3	2	6	13	44	51	7	126	15	11.1%
Sulfapyridine Plus Serum Case Deaths	1	..	..	..	5	8	1	..	..	..
<i>Sulfapyridine Plus Serum Fatality Rate</i>	33.3%	..	..	..	11.4%	15.7%	14.3%	..	..	..
Neither Sulfapyridine Nor Serum Cases	32	36	23	15	36	64	97	303	89	29.4%
Neither Sulfapyridine Nor Serum Deaths	14	8	2	2	8	22	33	..	..	..
<i>Neither Sulfapyridine Nor Serum Fatality Rate</i>	43.7%	22.2%	8.7%	13.3%	22.2%	34.4%	34%	..	..	..
Sulfathiazole Cases Only	12	24	13	4	14	12	7	86	6	7%
Sulfathiazole Case Deaths	1	..	..	..	4	1	..	..	..	..
<i>Sulfathiazole Fatality Rate</i>	8.3%	..	..	..	28.5%	8.3%	..	..	..	..
Sulfathiazole Plus Serum Cases Only .....	..	..	1	..	4	2	2	8	2	25%
Sulfathiazole Plus Serum Case Deaths .....	..	..	..	..	1	1	..	..	..	..
<i>Sulfathiazole Plus Serum Fatality Rate</i> .....	..	..	..	..	25%	50%	..	..	..	..
Sulfathiazole Plus Serum and Sulfapyridine Cases Only .....	..	..	..	..	1	1	..	2	..	..
Sulfathiazole Plus Serum and Sulfapyridine Deaths .....	..	..	..	..	..	..	..	..	..	..
<i>Sulfathiazole Plus Serum and Sulfapyridine Fatality Rate</i> .....	..	..	..	..	..	..	..	..	..	..
Sulfanilamide Cases Only .....	..	1	..	1	2	..	..	4	..	..
Sulfanilamide Case Deaths .....	..	..	..	..	..	..	..	..	..	..
<i>Sulfanilamide Case Fatality Rate</i> .....	..	..	..	..	..	..	..	..	..	..
Sulfanilamide Plus Serum Cases Only .....	..	..	..	..	..	1	..	1	..	..
Sulfanilamide Plus Serum Deaths .....	..	..	..	..	..	..	..	..	..	..
<i>Sulfanilamide Plus Serum Fatality Rate</i> .....	..	..	..	..	..	..	..	..	..	..
Sulfanilamide Plus Sulfapyridine Cases only .....	..	..	..	..	..	1	..	1	1	100%
Sulfanilamide Plus Sulfapyridine Deaths .....	..	..	..	..	..	1	..	..	..	..
<i>Sulfanilamide Plus Sulfapyridine Fatality Rate</i> .....	..	..	..	..	..	100%	..	..	..	..
Total Cases	132	221	160	121	318	385	240	1577	194	12.3%
Total Deaths	24	9	5	8	31	60	62	..	..	..
Total Fatality Rate	18.1%	4.1%	3.1%	2.5%	9.7%	15.6%	25.8%	..	..	..

death rate from pneumonia had been so reduced that it caused fewer deaths than tuberculosis or apoplexy, falling to fifth place among the causes of death.

Table 2 lists the pneumonia cases with fatality rates and treatment reported in Newark during 1940. The total of cases under review was 1,577 and the mortality for all medications was 12.3 per cent. Most cases (1,366 out of 1,577) were treated in hospitals, the remainder in private homes.

Table III gives the pneumonia cases broken down into age periods.

No Serum or Sulfapyridine—Pneumonia cases that received no medication with serum or sulfapyridine or its derivatives numbered 303, with a mortality of 29.4 per cent. The fatality rate was highest under one year of age, 43.7 per cent. Over one year and under five years, the death rate was 22.2 per cent. The age group fatality then decreased until 25

to under 45 years, with a similar case fatality rate. The next highest was in the group over 45 years and under 65 years with a case fatality of 34.4 per cent.

Serum Cases Only—Only 13 cases in 1940 were treated with serum alone. The fatality rate in this group was 7.7 per cent.

Sulfapyridine Cases Only—There were 1,033 cases treated with sulfapyridine alone, with a case fatality of 7.4 per cent. Highest case fatality here was in the group over 65 years, 22 per cent. Lowest case fatality was at the age periods over 15 and under 25 years, 1.1 per cent. A high fatality was also registered at under one year of age, 9.4 per cent.

Sulfapyridine Plus Serum—There were 126 cases treated with sulfapyridine plus serum. Case fatality in this group was 11.1 per cent.

Sulfathiazole Only—There were 86 cases treated with sulfathiazole alone, with a total fatality of 7 per cent.

CONCLUSIONS

In 1940, in the City of Newark, out of 1,577 reported cases of pneumonia, 1,123 or 71 per cent, were treated with chemotherapy alone.

In 1,033 sulfapyridine treated patients, a fatality rate of 7.4 per cent was obtained. The

total fatality rate of 12.3 per cent in 1940 constitutes a record for Newark.

Chemotherapy played the major rôle in the reduction of pneumonia mortality.

94 William Street

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THE IDEAL PHYSICIAN IS CONJURED UP in the mind of general public as a man of good intellect and learning, a man who can find a large part of his recreation in his books, his pen or his microscope. Offhand this may sound like an extremely pedantic or priggish statement; certain it is, that too many of us fall far short of this concept of a physician. But if you think that it is wrong, just look about for a moment, among your colleagues, and see if those whom you consider to head the list as fine physicians, those for whom, as practitioners and as men, you have the greatest respect, do not by natural inclination or force of training or both, satisfy this concept.—"Disease and the Man"—Lapham.



THAT TIRED FEELING MAY BE JUST A myth. At least the fatigue doesn't really occur in the muscles. After a muscle has performed the same movement over and over again, until the subject says he's too tired to do it again, an electrical stimulation of the muscle will jump it into action once more. When a muscle works, by-products are poured out into surrounding tissue (chiefly lactic acid and carbon dioxide). The circulatory system has to carry them off, and if the oxygen supply isn't sufficient for this, the by-products accumulate, causing the fatigue-sensation. But it's the circulatory system that's defaulting and the brain that's recording the fatigue sensation. The muscle itself is still ready for business.

HEALTH NEEDS AMONG NEW JERSEY YOUTH A PRELIMINARY REPORT

By DANIEL BERGSMAN, M.D., Trenton, N. J.

State Health Consultant, National Youth Administration for New Jersey

Read before the N. J. Tuberculosis League in Atlantic City, June 4, 1941.

In 1940, the National Youth Administration established a nation-wide health program. The purpose of this was twofold: to discover defects that might be corrected before these youth would be called as draftees; and to classify each youth to permit more intelligent guidance during his N. Y. A. work experience. For example, this procedure would prevent the placement of a youth with a potential hernia in heavy construction work.

BACKGROUND

The N. Y. A. health program in New Jersey is co-sponsored by the New Jersey State Department of Health. The State Health Consultant and the State Health Supervisor were appointed in January, 1941. A survey of facilities was made immediately. Questions of transportation of youth, equipment, supplies, detailed plans of procedure, etc., were carefully considered. An educational program of lectures, discussions, motion pictures and leaflets was carried on among the youth with special emphasis on tuberculin testing and blood testing to acquaint them with the value of these procedures. An N. Y. A. Health Advisory Committee was organized consisting of five physicians,* a dentist and a public health nurse.

Doctors interested in the examining of youth on this program submit applications on official forms. The names of those who apply are sent to their county medical societies so that we may be informed if any of the applicants are not professionally acceptable.

PROCEDURE

The youth assemble in groups. On the first day each brings a specimen of urine. A sample of blood is withdrawn for a serologic test; a tuberculin test is given intradermally using

purified protein derivatives of second test strength and, finally, a color vision test is performed. On the second visit, two days later, the skin test is read and the positive reactors receive a chest x-ray. The 14" x 17" standard film is used. The films, developed in a portable darkroom, are then examined by roentgenologists skilled in this type of work.

Complete physical examinations are performed either by teams of specialists at some urban center or at the private offices of physicians in rural areas. This health program includes diagnosis and assistance in obtaining remediable medical and dental care from existing organized sources such as private physicians and dentists or through clinics for indigent youth. The program does not include treatment except to the relatively few youth living at Resident Centers.

LABORATORY FINDINGS

The preliminary testing began during the second week of April, 1941. These youth range from 17 to 25 years in age. There are about an equal number of boys and girls and ten per cent are Negroes. To date, of 2316 youth, 2264 (98.5 per cent) were blood-negative, 17 doubtful and 25 gave positive reactions for reagin. The small number of positive reactors is not surprising considering the age of the group. The positive and doubtful reactors are being followed, given further examinations as necessary, and sent for treatment when indicated.

Of the urine samples, 1.4 per cent showed some albumin and 2.4 per cent gave a reaction with Benedict's solution. These youth receive a second test and, if the albumin or sugar persists, a complete microscopic urinalysis is done. Definite abnormalities are followed up through Area Health Supervisors by specific referral for proper care.

Of the youth whose tuberculin skin tests were read, about 46 per cent gave a positive reaction to the second test strength of P. P. D.

* The physician-members are: Drs. R. A. Schaaf of Newark, Joseph Morrow of Oradell, W. G. Alexander of Orange, F. P. Lee of Paterson and Chester Ulmer of Gibbstown; all members of The Medical Society of New Jersey.

This is higher than anticipated, but to date most of the tests have been done in urban centers and the rate for the whole State may prove to be lower. Over 1000 chests have been x-rayed. Of these, 2.1 per cent had inactive pulmonary tuberculosis. Findings included Ghon tubercles, calcified plaques and well circumscribed fibrotic lesions which, by x-ray, seemed well healed. Four youth (0.5 per cent) were found by x-ray to have active pulmonary tuberculosis. Two were minimal, one moderately advanced, and one far advanced. This latter patient had artificial pneumothorax with a cavity 1.5 cm. in diameter and an early active lesion was present on the opposite side. The cavity was held open by two heavy bands of adhesion. Prior to the x-ray report, this young girl had been working every day in close association with other teen age girls.

HEALTH CLASSIFICATIONS

Here is the Health Status Classification used throughout the nation in connection with the N. Y. A. Health Program. *Class 1* means fit for any work or athletic activity; no defects present or only very slight defects. *Class 2* means fit for any work or athletic activity. Abnormal conditions present can be corrected by proper measures which may be medical, dental, or by special exercise or diet. *Class 3* means fit for almost any kind of employment or recreational activity. This includes minor defects not thought to be amenable to correction but not severely handicapping. In this case the physician indicates the work to be avoided, or specifically approves the work assignment given to the youth. *Class 4* means fit only for certain kinds of employment or recreational activity. Here too the physician must approve the assignment and state whether there is necessity for medical supervision of the youth during employment. *Class 5* means temporarily unfit for any employment or recreational activity. Classification in *Class 5* means subsequent reclassification after termination of the temporary period of unemployability. *Class 6* means permanently, or for a prolonged period, unfit for any employment or recreational activity. Thus Classes 1 through 6 cover, by

careful grading, all youth from those in perfect health to those unfit for any activity.

CLINICAL FINDINGS

To date only 6 per cent have been placed in *Class 1* and 80 per cent in *Class 2*. A large proportion of the latter were physically well except for dental caries. Actually 51 per cent of the youth would have been in *Class 1* if it were not for dental pathology; thus we find that 92 per cent were either free of defects, had only very slight defects or had abnormal conditions which could be corrected by proper measures. This presents a huge medical and dental problem because 86 per cent of these youth have correctable defects. If these are corrected soon the nation, and this State, will have many young citizens of which it can be truly proud. Then these young men and women would be found healthy and fit to serve their country as needed. The N. Y. A. health program of New Jersey will do its utmost to help these youth have their remediable defects properly treated. One per cent of the youth had minor defects not amenable to correction. These were in *Class 3*. Seven per cent were in *Class 4* because they were fit only for certain kinds of employment. Thus far no youth has been found in *Classes 5* or *6*.

Refraction to correct astigmatism was recommended in 31 per cent of the youth. Tonsillectomy was recommended in 7 per cent, circumcision in 2 per cent, and hernia repair in 1 per cent.

SUMMARY

We have only begun our N. Y. A. Health Program. Already many correctable defects have been found. The principal defects were dental caries, refractory errors and a few cases of tuberculosis. Two of these were minimal but active, another moderately advanced and active, and, most dangerous of all, an advanced bilaterally active case with cavitation. We hope that, through this program and by active co-operation with the organized medical, dental, nursing and social service professions, these youth will obtain a thorough diagnostic service and will have their remediable defects corrected and their future health assured.

ANESTHESIA AS A CAUSE OF OBSTETRIC DEATH IN ESSEX COUNTY

MATERNAL WELFARE ARTICLE NUMBER SIXTY

ALFRED MEURLIN, M.D., East Orange, N. J.

Read May 15, 1941, before the Maternal Welfare Committee of the Essex County Medical Society

Until comparatively recent years, inhalation anesthetics have been the mainstay of pain relief in childbirth. Sir James Y. Simpson was the first to use ether in obstetrics, when on January 19, 1847, he did a version and extraction. In November, 1847, he discovered the anesthetic properties of chloroform and used it in labor cases in preference to ether. This aroused a storm of criticism, largely religious, which seems amusing to us now in our own more enlightened time. The administration of chloroform to Queen Victoria of England in 1853 and 1857 focussed medical and lay attention on its merits in labor. The interest aroused was similar to the discussion raging about the barbiturates and other analgesic and amnesic drugs of the present day. No one now will deny the inestimable value of the anesthetic gases during the second stage of labor when properly given.

During the past four years, in Essex County, seven deaths occurred during or soon after labor, directly caused by aspiration of stomach contents. In many other deaths the primary cause was not given as asphyxia or aspiration pneumonitis, but pulmonary infiltration, no doubt, hastened or complicated the final exitus or increased post-partum morbidity. This was confirmed by physical or x-ray findings. Because of their controversial nature, the latter group have not been included in this study. The following cases were among those investigated by the Maternal Welfare Committee of Essex County during the past four years. Those occurring since 1939 have been discussed in meetings open to all physicians. It is felt by the Committee that a free discussion and an attempt to answer the question, "In what better way can I handle a similar situation the next time?", is proving of great value. Waters and Harris¹ state, "It was formerly taught that parturient women enjoyed a certain degree of

immunity against the bad effects of anesthetics, especially chloroform and ether. While this may be true as far as obstetric analgesia is concerned, it does not apply to surgical anesthesia with these drugs. Depression of cellular activity of the respiratory tract is now a recognized effect of the pain-relieving drugs. * * * A woman with absent or fogged mental faculties may fail to turn her head, change her position or otherwise safely supervise her condition when vomiting occurs. Opiates, barbiturates and other non-volatile drugs as well as inhalation agents in sufficient doses, all cause depression of the respiratory center in mother and child. * * * The ease with which vomitus may be aspirated is not generally appreciated." Hall,⁵ however, in a series of 15 cases of aspiration pneumonias could find no relationship between analgesia and vomiting. It has been stated by eminent authorities that barbiturates, even in large doses, do not entirely abolish the gag reflexes. We too find no causative effect of the barbiturates upon vomiting but on the contrary, feel that the vomiting reflex becomes reduced after moderate sedation.

Deaths from anesthesia occur in the best risks. They are caused by aspiration of regurgitated stomach contents, either solid, fluid, or both. Deaths of this type occur more frequently during labor than among patients receiving an anesthetic for general surgery. Flagg⁶ reminds us that, "during induction of the anesthetic, serious complications may follow; sudden vomiting, aspiration, respiratory obstruction and respiratory failure in a patient who has had a recent meal. By liquid ether finding its way into the airway. During the stage of maintenance danger is faced from progressive respiratory failure, from basal plus general anesthesia, from progressive respiratory failure due to respiratory obstruction giving rise to a low grade of continuous anoxemia; from pro-

tracted spasm of the glottis during gas anesthesia resulting in a rapid double atelectasis; from a high level of anesthesia immediately following delivery (the buffer, consisting of the baby and placenta, having been removed). When recovery begins to take place, serious results may follow from neglect of the patient on the table, in transfer or when returned to bed, from vomiting, from the aspiration of foreign bodies, from hemorrhage, anemia and anoxemia. Post-operative pulmonary complications are in the larger part due to aspiration of vomitus, saliva, etc. Ever present suction, active reflexes combined with the correct position following delivery reduces morbidity and mortality."

There seems to us, from our study of these cases, two chief causes of difficulty: First, a lack of pre-anesthetic preparation and haste, especially failure to keep the stomach empty. This particularly applies to many Cesiarians, which could safely be postponed until the patient has been properly prepared. Second, a lack of team work between the accoucheur and the anesthetist causing the latter to be hurried and, in case of vomiting, pushing the anesthetic instead of clearing the airway and drying the pharynx. Montgomery,⁴ reviewing maternal welfare in Philadelphia, found a decrease in the general mortality rate of 24 per cent over a five-year period beginning in 1931. However, for maternal deaths during labor or within 24 hours thereafter, there was no decrease in the rate. From his figures, one receives the impression that mistakes in judgment and errors in technique (as represented by deaths in the intrapartum period) accounted for the slowness of improvement in obstetric practice. Lahey⁸ asks, what "better origin can there be for many cases of post-operative pneumonia than the occlusion of a bronchus, the accumulation of organisms in the warm moist secretion of the occluded bronchus and the products of a pneumonitis?"

The *symptoms* are those of asphyxia, following the vomiting of a large food bolus and subsequent aspiration into the trachea. Death may result rapidly unless obstruction to respiration is quickly removed. Aspiration of fluid material sets up a chemical pneumonitis. The

x-ray picture may be that of bronchopneumonia but clinical criteria are different. The temperature reaction is not so high; cyanosis is more marked, the pulse and respirations are likely to be more rapid, sputum is more profuse and the bacteria are usually secondary invaders.

CASE 1

Nullipara, 21 years old, white. She had a faint systolic murmur antepartum but otherwise was always very healthy. Labor lasted about 12 hours. She received morphine sulphate grs. $\frac{1}{4}$, scopolamine grs. 1/150 ten hours before delivery. At 8 a. m. she had breakfast. The caput was visible at 9:30 a. m. and she was delivered at 11:20 a. m. She expired on the table from the aspiration of food still present in her stomach from breakfast, which had been eaten 3 hours before.

CASE 2

Nullipara, 31 years old, white. Labor was normal, lasting 20 hours. Medication during the first stage consisted of pentobarbital grs. $4\frac{1}{2}$ and morphine sulphate grs. 1/6. Gas oxygen ether was administered from 11:05 to 11:38. During the anesthetic the patient vomited bile and mucus with much gagging and coughing. On the first day postpartum her temperature rose to 103.5. X-ray at this time showed marked infiltrative and exudative changes in the entire right lung and the lower portion of the upper lobe and the entire left lower lobe. Temperature and pulse continued to rise. The patient became more dyspneic and cyanotic, and died on the second day postpartum.

CASE 3

Multipara, 32. Labor was slow. A median axis-traction-forceps delivery was done at the end of 42 hours. The placenta was delivered complete with membranes. During labor, which had been induced by the method of Watson, she had had pentobarbital grs. 3 and scopolamine 1/200; paraldehyde drs. 5, morphine sulphate grs. $\frac{1}{4}$. Pentobarbital grs. 3 were given later in the first stage. Pituitrin 1 c.c. was administered shortly before delivery. Following delivery the patient reacted fairly well, although her pulse continued above 100. Shortly thereafter it was noted that she was cyanotic, and many râles were audible throughout her chest. There was an emesis of yellow, blood-stained, frothy fluid. Her respirations became more labored, and she died about 4 hours after being delivered. Gas oxygen-ether had been given for delivery.

CASE 4

Multipara, 21 years old, colored. Her antepartum course showed no abnormalities. She had gained 17 pounds. Blood pressure had varied from 110/60 to 140/80. She was not toxic and had had no abnormal bleeding. She had a deformed pelvis for which a

previous section had been done. For these reasons another section was elected. She took the anesthetic badly; that is, it took an unusually long time during which she struggled and vomited. A low flap operation was done without difficulty. During closing of the fascia the patient ceased to breathe and could not be revived.

CASE 5

Nullipara, 32 years old, white. Antepartum she had gained 16 pounds. Blood pressure ranged from 118/80 to 130/80. She was not toxic and had had no abnormal bleeding. Labor was delayed after 10 hours by a transverse arrest of the vertex for which a rotation with Kielland forceps, followed by the application of Dewees, was done for extraction. Following the manipulation there was active postpartum hemorrhage and shock. The patient was markedly dyspneic and cyanotic. The anesthetic had been given for 40 minutes, during which time there was some vomiting with subsequent aspiration. X-rays showed exudative infiltration and partial atelectasis at the right base, also slight congestion of the left lower lobe with good aeration in the upper lobes. The impression of a medical consultant who saw her the following day was an aspiration bronchitis with a few broncho-pneumonic patches. The patient died about 20 hours postpartum.

CASE 6

Multipara para 12. A Caesarean section was elected to deliver the baby and sterilize the patient at one operation. The anesthetic lasted 2 hours. Forty-eight hours postpartum she developed a lobar pneumonia of the right lung, following that a pneumonitis of the left lung. No information was available as to aspiration or type of the anesthetic.

CASE 7

Multipara. Antepartum she was not toxic and had no bleeding. Her weight and blood pressure remained within normal limits. Delivery was normal and spontaneous. She became cyanotic during the course of the anesthetic, vomiting large amounts of mucus which were aspirated into her lungs. The patient was still slightly cyanotic on her return to her room. X-rays showed pathology at both bases and emphysema diagnosed as pulmonary embolism.

Taking our lessons from the death certificates leads us naturally to a rational therapy. Treatment of aspiration pneumonia is almost entirely prophylactic. Diet in labor should consist solely of high caloric fluids. If the stomach appears to be definitely distended due to gastric atonia it should be emptied by means of a Levine tube before the administration of any anesthetic. The closed method of administering a gas seems to be a greater hazard than one in which the mask can be quickly removed from the patient's face in case of vomiting. The mask should never be fastened to the face. In case of vomiting the accoucheur should cooperate with the anesthetist, seeing that the patient is turned on her side and the regurgitated contents allowed to run out of her mouth. The pharynx should be aspirated until dry before the anesthetic is resumed. An aspirator might well be standard equipment in every delivery room.

SUMMARY

1. Seven maternal deaths due to the administration of an anesthetic occurred in Essex County during the past four years.
2. Aspiration of stomach contents is a great hazard in obstetrics.
3. A delayed emptying time of the stomach

during labor is a factor that should be kept in mind.

4. Pre-anesthetic preparation of the obstetric patient should not be neglected.

5. The anesthetist should be prepared to clear the pharynx by postural drainage and aspiration if vomiting occurs.

DISCUSSION

Dr. W. M. Lutz: Pre-operative preparation, especially the use of intravenous glucose, has been of great value.

Dr. F. E. Hubbard: A dilated stomach is very dangerous during anaesthesia. It can readily be emptied by a Levine tube if the stomach contents are liquid. If solid matter is present the emesis caused by the passage of the tube itself is of value. When the vomiting reflex is active the patient may

be anaesthetised with her head on the side. Early aspiration may be life saving. Salines and glucose intravenously and a high vitamin diet should be given before anaesthesia.

Dr. M. G. Kilborn: I question whether the patient who died following a Caesarian section represented an anaesthetic death. The cause was more probably shock. Vomiting can usually be avoided by passing rapidly from the second to the third stage

of anaesthesia by using cyclopropane. Intravenous anaesthesia might also be used for induction to avoid vomiting. If vomiting does occur the patient should immediately be placed in Trendelenburg position and aspirated.

Dr. A. L. Reich: I should like to know how it is possible to have time to prepare a maternity case properly. How is it possible to know if the stomach is dilated? I persuaded Dr. Kessler to allow me to use spinal anaesthesia for his Caesarian operations

and we feel that this is best for the mother and baby.

Dr. Carl Ill: The greatest hazard is from the inexperienced intern anaesthetist.

Dr. A. W. Bingham: Nobody has spoken about chloroform and I should like to say a good word for it. It has the advantage of a rapid induction without causing vomiting. Some death certificates give embolus as the cause, when the real cause of death is asphyxia due to the effects of an anaesthetic.

158 Harrison Street

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4. T. L. Montgomery: Obstetrical Amnesia, Analgesia and Anesthesia. J. A. M. A., Vol. 108, No. 20, pp. 16-79.
5. Charles Hall: Aspiration Pneumonitis. J. A. M. A., Vol. 114, No. 9, p. 729.
6. P. Flagg: The Art of Anesthesia, 1939.
7. DeLee: Principles and Practice of Obstetrics, 5th Edition.
8. Lahey, Southern Medical Journal, January 1938, Vol. 31, No. 1, pp. 29-35.

A LESSON FROM A DEATH CERTIFICATE NUMBER THIRTY-TWO

For two weeks patient had slight vaginal bleeding. Suddenly went into shock. Admitted to hospital in poor condition.

Transfusion followed by intravenous fluids. Patient was prepared for operation but died before it was done.

Patient in hospital 10 hours 55 minutes before

death. Autopsy showed a ruptured ectopic with hemorrhage.

Even though in state of shock could not operation have been done sooner—at same time as transfusion and before the intravenous?

A. W. BINGHAM, M.D.

NUMBER OF CHILDREN RECEIVING FREE STATE BIOLOGICALS SINCE JULY 1, 1940

DIPHTHERIA TOXOID

County	Total to Apr. 30	Month of May	Total to May 31	Average per Month
Atlantic	7168	23	7191	653.7
Bergen	2337	450	2787	253.3
Burlington	550	458	1008	91.6
Camden	1233	90	1323	120.2
Cape May	36	18	54	4.9
Cumberland	91	27	118	10.7
Essex	7019	742	7761	705.5
Gloucester	246	27	273	24.8
Hudson	4157	781	4938	448.9
Hunterdon	122	0	122	11.9
Mercer	2374	504	2878	261.6
Middlesex	615	14	629	57.1
Monmouth	988	12	1000	90.9
Morris	460	82	542	49.2
Ocean	177	0	177	16.1
Passaic	3767	272	4039	367.1
Salem	604	261	865	78.6
Somerset	261	4	265	24.1
Sussex	10	5	15	1.3
Union	1477	916	2393	217.5
Warren	65	9	74	6.7
Totals	33757	4695	38452	3495.6

SMALLPOX VACCINE

County	Total to Apr. 30	Month of May	Total to May 31	Average per Month
Atlantic	680	13	693	63.
Bergen	1340	282	1622	149.2
Burlington	273	34	307	27.9
Camden	1328	46	1374	124.9
Cape May	57	46	103	9.3
Cumberland	136	17	153	13.9
Essex	5949	539	6488	589.8
Gloucester	213	38	251	22.8
Hudson	3151	260	3411	310.1
Hunterdon	25	1	26	2.3
Mercer	1030	119	1149	104.4
Middlesex	867	21	888	80.7
Monmouth	364	732	1096	99.6
Morris	544	32	576	52.3
Ocean	21	0	21	1.9
Passaic	2356	211	2567	233.3
Salem	250	157	407	37.
Somerset	153	3	156	14.1
Sussex	21	0	21	1.9
Union	1212	167	1379	125.3
Warren	193	28	221	20.1
Totals	20163	2746	22909	2082.6

STATE SOCIETY ACTIVITIES

MIDDLESEX COUNTY'S BIRTHDAY PARTY

Flanked by high officials of The Medical Society of New Jersey, and by representatives from 17 counties, members of the Middlesex County Medical Society celebrated the 125th anniversary of the chartering of their organization at a dinner meeting, June 11, at the Walker-Gordon Farm in Plainsboro. Attending the party were Dr. Thomas K. Lewis, President; Dr. Elias J. Marsh, President-Elect, and Dr. Alfred Stahl, Secretary of The Medical Society of New Jersey. From the Board of Trustees came Dr. William F. Costello, Chairman; Dr. Samuel Alexander of Bergen County and Dr. James F. Norton of Hudson. The Executive Offices contributed Dr. LeRoy A. Wilkes, Executive Officer, and Dr. Henry A. Davidson, Editor of the *Journal*. Other distinguished guests included Mr. Henry Jeffers, President of the Walker-Gordon Laboratories; Dr. Watson B. Morris, Junior Fellow of The Medical Society of New Jersey, and the general dynamo of the evening's entertainment, Past-President William J. Carrington of Atlantic City, who starred as the toastmaster.

From the counties came Drs. Subin (Atlantic), Tracy (Camden), Smith (Hunterdon), Weber (Essex), Cox (Mercer), Johnson (Passaic), Ely (Somerset), Conty (Hudson) and Buchanan (Warren).

Middlesex County itself supplied a hundred members to the combination farm-tour, dinner and meeting, under the chairmanship of Dr. R. J. Faulkingham, President of the Middlesex County Medical Society.

FARM TOUR

The festivities began with a tour of the Walker-Gordon Farm. A guide walked the doctors around that unique cow-carousel, the rotolactor, through which fifty cows are scientifically, simultaneously, and quite completely milked in a tiled amphitheatre sparkling like an operating room. The method of pasteurizing, homogenizing and bottling the milk was then demonstrated. Next stop was a model cattle-barn where obviously contented cows were housed and fed. Not the least interesting of the guide's explanations was his story of the technique of artificially inseminating the animals.

The method of dehydrating the vitaminized fodder was next exhibited, after which the doctors had the opportunity of seeing (from a distance) the isolation hospital in which cows in suspicious health were observed. Next sta-

tion on the milky way (to quote Dr. Carrington) was the Club-House, where Mr. Jeffers, with host-like geniality, welcomed the doctors in a brief address of greeting. A chicken dinner next took the attention of the members. Having disposed of this, the Society settled down to hear Dr. Faulkingham introduce the toastmaster.

DR. CARRINGTON'S ADDRESS

Dr. Carrington reminded his audience of the state of the world in 1816, when the Middlesex County Medical Society was chartered. At that time, he pointed out, Britain had just defeated an arrogant ex-corporal who had tried to set himself up as dictator of Europe. There were no cystoscopes, otoscopes or proctoscopes; not even a peritoneoscope. "In the absence of instruments," explained Dr. Carrington, "doctors had to use their brains."

DR. KLER'S ADDRESS

Dr. Carrington then introduced Dr. Joseph Kler, Chairman of the Public Relations Committee of the Middlesex County Medical Society, who reminded his auditors that Middlesex was the cradle of The Medical Society of New Jersey, and therefore the nursery of Organized Medicine in the United States. Dr. Kler named the pioneers of medicine in the Middlesex area, lauding their major part in the formation of the State Society. The first President of The Medical Society of New Jersey, Dr. Kler pointed out, was a Middlesex doctor: Robert McKean of Perth Amboy; while the third President, John Cochrane of New Brunswick, an early promotor of medical licensing laws, was a Surgeon-General in George Washington's Army. Dr. Kler traced the history of the county's profession, and its rôle in the development of the State Society, from Robert McKean, the founder, to Dr. David English of New Brunswick, 112th President of the Society and first Editor of its *Journal*.

DR. LEWIS' ADDRESS

A rousing cheer welcomed Dr. Lewis, who briefly listed the aims of his administration. "The entire membership of the Society," explained Dr. Lewis, "will constitute a Committee of the Whole devoted especially to two functions: the implementation of our Medical Service Plans and the prosecution of New Jersey's share in the medical preparedness program."

DR. MORRIS' ADDRESS

Climax of the evening was an account of the development and structure of The Medical Society of New Jersey by Dr. Morris, who dramatized his presentation with lantern slides of

places and persons notable in the history of our Society.

As the members thronged the club-house lobby, leaving the meeting, the theme-song of the conversation was a universal "good bye * * * and it was a grand party."

ACTIVITIES OF THE COMMITTEE ON EDUCATION AND HOSPITALS

Presented by ARCANGELO LIVA, M.D., F.A.C.S., Chairman; SAMUEL BARBASH, M.D., F.A.C.P.; CHARLES A. FUREY, D.O., and A. STANLEY MYERS, D.C.

This is the third article in a series presented by the State Board of Medical Examiners of New Jersey

This Committee is composed of the above-named four members of the Board. As the reader can see, two of them are Doctors of Medicine, one an Osteopathic Physician and one a Chiropractor.

All matters concerning medical education or hospitals are referred to this Committee for study and recommendation to the Board. The Committee passes on all applications for approval and rating as Medical Colleges, Osteopathic Schools, Chiropractic Colleges, Chiroprody Schools, as well as Midwifery Schools. It also inspects and approves hospitals for interne training.

Owing to the fact that the Board has no adequate financial means of inspecting all medical schools and general hospitals throughout the country, the Board accepts the rating of the Association of American Medical Colleges concerning medical schools and the rating of the American Medical Association for hospitals outside of the State of New Jersey. Nevertheless it has a prospectus of standards and minimum requirements of its own for professional schools, as well as for hospitals training internes. The American Medical Association requires of a hospital for interne training a minimum of one hundred (100) beds and seventy-five (75) ward patients average per diem, besides the physical and scientific equipment, whereas, our Board requires a minimum of seventy-five (75) beds and fifty (50) ward patients average per diem.

The Board also takes into consideration, upon the recommendation of this Committee, hospitals which may not come up to the minimum requirements, if their geographical location and community needs warrant such consideration. All hospitals which cannot qualify under the requirements of the American Medical Association file applications with the Board for inspection and approval. A majority of Committee members, in most instances, usually inspect such hospitals and check up the number of beds and patients with statistics relating to

the different classifications of cases. Only general hospitals are eligible for such inspection and approval.

The Committee follows a questionnaire prepared by the Board for recording all the information desired. The Committee inspects even the internes' living quarters; the character of staff, and reviews staff conferences and meetings; the type of laboratory and the work done in it; X-ray Department and the equipment used in anesthesia. History and records of cases are scanned as to their completeness or deficiencies. Percentage of necropsies is checked. The record-room or system of keeping records is thoroughly gone into by the members of the Committee. The internes of the hospital under inspection are questioned as to the type of internship they receive and the extent of instruction imparted to them by the hospital staff.

The Committee's particular interest is in checking the out-patient department and the work done in this department by the internes. Likewise, we determine if he has a complete clinical laboratory training to which, whenever possible, the interne ought to devote about eight weeks, in order to comply with the requirements for licensure in certain states. Necropsies, as far as possible, should be performed by the interne under the direction of the pathologist and the percentage performed in the hospital is usually looked upon as an index of the extent of pathologic teaching carried on in the hospital.

The records must also show that the interne has obtained satisfactory instruction and experience in the various kinds of anesthesia under experienced medical supervision; that he has delivered a certain amount of normal maternity cases and has assisted in abnormal cases; that he has received from the roentgenologist a reasonable amount of instruction in the technic and the therapeutic use of the roentgen ray, as well as in the interpretation of plates and fluoroscopic findings; that he has

received some instruction in dietetics under some qualified staff member, and in the feeding of both infants and adults, as required in various diseases or conditions. A reasonable amount of technical experience under a trained dietitian is also desirable.

The hospital must satisfy the Committee that they have a set of printed or written rules and regulations defining the rights, duties and privileges of the interne; a copy of which should be furnished to each interne. If and when the necessity arises, the Committee emphasizes that the object of the general internship is to round out the general practice of medicine with due preparation and confidence, and not to equip him to enter directly into any specialty.

Finally, the hospital is supplied with a survey blank in duplicate which must be filled out by the superintendent or one in charge of the interne service in the hospital. The Board desires also to have on record:

a. An outline of the course, or order, in which the interne progresses through the different departments.

b. The name of responsible instructor, time and work required in each department.

On many occasions hospital authorities have not been aware of or acknowledged the fact that the Board is the supreme authority in the State of New Jersey, legally constituted, to inspect and rate hospitals for interne training.

MEDICAL SCHOOLS

The Committee has formulated an outline of "The Requirements for an Acceptable College, Teaching Any Branch of Medicine and Surgery", which has been approved by the Board, and this procedure is followed in the inspection of a college. The requirements include:

- | | |
|-------------------------|--------------------------------|
| 1. Organization. | 7. Requirements for admission. |
| 2. Faculty. | 8. Publications. |
| 3. Plant. | 9. Library. |
| 4. Clinical facilities. | 10. Curriculum. |
| 5. Resources. | |
| 6. Administration. | |

All professional schools seeking the approval of the Board must comply in every detail with the above requirements and the Board finally acts upon the recommendation made by the Committee.

When in 1935 an amendment to the Medical Practice Act was adopted by the Legislature granting to the Osteopathic Physicians the privilege of taking a special examination to obtain full rights to practice medicine and surgery, this Committee prepared the two-year curriculum necessary to gain admission to this examination.

Since the Uniform Medical Practice Act was enacted the Committee, with the approval of the Board, has compiled also the curriculum for the year of post-graduate work, which may be accepted by the Board in lieu of the interne year, as provided in the Act.

This Committee has considered minimum grades required in every subject by a candidate whereas minimum mark required years ago was 50 per cent in any one subject, with a total average of not less than 75 in all subjects, for the last two years the minimum was raised to 65 per cent. If the candidate fails in one subject, receiving less than 65 per cent, he is reexamined in that one subject, but if he receives less than 65 per cent in two subjects, the candidate must take over again the entire examination in the nine subjects.

TRUSTEES' MEETING

The reorganization meeting of the Board of Trustees was held on May 22nd at 2:15 p. m. at Haddon Hall, Atlantic City, New Jersey.

Present were: Drs. Costello, Hollinshed, Hornberger, Londrigan, Crowe, North, Green, Marsh, Lewis, Lee, Stahl and Young. Drs. McBride and Hawkes were excused. Also present were Dr. Morris, Dr. Barkhorn and Dr. Wilkes.

Dr. William F. Costello, Chairman of the Board of Trustees for the past year, thanked the Board members for their coöperation throughout the year, and appointed Dr. Thomas K. Lewis temporary Chairman for the election of the Chairman to serve during 1941-42.

Dr. Crowe nominated Dr. William F. Costello for Chairman of the Board of Trustees. Seconded by Dr. Lee.

Dr. Stahl moved that the nominations be closed and that the Chairman pro-tem cast a ballot declaring Dr. Costello the Chairman of the Board of Trustees. Seconded and unanimously carried.

Dr. Hornberger nominated Dr. Aldrich C. Crowe for Secretary of the Board of Trustees. Seconded by Dr. Hollinshed.

Dr. Lewis moved the nominations be closed and the Chairman cast a ballot declaring Dr. Crowe Secretary of the Board of Trustees. Seconded and unanimously carried.

The meeting was adjourned at 2:20 p. m.

ALDRICH C. CROWE, M.D.,

Secretary.

A SPOTLIGHT ON THE A. M. A. MEETING

The Cleveland meeting of the A. M. A. was harmonious and helpful. The weather was generally fair and the programs and exhibits were very good. Cleveland's hospitality was all one could desire and the organization and hotel facilities were adequate.

Diversions such as baseball games, movies and parties of various kinds were available during the week for the members and their wives.

St. Louis, Missouri, was chosen for the 1944 meeting. An invitation to come to Atlantic City in 1945 was sincerely and tactfully presented by Dr. Andrew F. McBride to the House of Delegates. Atlantic City had already been chosen for the 1942 meeting.

The addresses of the retiring and incoming Presidents were excellent and contained constructive thoughts worthy of study.

The members of the House of Delegates

were diligent and agreements were quickly reached upon such important matters as (1) Medical Preparedness, (2) appeal on the court decision in the matter of the U. S. A. vs. the A. M. A., (3) place for 1944 meeting, (4) elected officers and committees, and (5) safeguards for the profession and public alike. Ninety New Jersey M.D.'s were registered and our Society's Official Delegates were faithful and active in the meetings. In addition to the elected Delegates from New Jersey these meetings were attended by Past-President Dr. Carrington, Second Vice-President Dr. Londrigan and your Executive Officer.

The Section Meetings were well attended and interesting. Many of the papers presented and the details of the section meetings will be found in forthcoming A. M. A. Journals.

LEROY A. WILKES, M.D.,
Executive Officer.

SUPPLEMENTARY LIST OF MEMBERS NO. 3

to the

OFFICIAL LIST OF MEMBERS, MARCH 15, 1941

The figures in parenthesis refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

ACTIVE MEMBERS

Angelillo, Marc C., 169 Bloomfield av., Newark (7)
Bell, Thomas, 340 Belmont av., Newark (7)
Benedict, Alfred C., 121 Irvington av., So. Orange (7)
Beyer, Othmar J., 42 Laurel av., Irvington (7)
Brodkin, Louis A., 872 Chancellor av., Irvington (7)
Caldwell, Julius A., 45 S. Mountain av., Montclair (7)
Conlon, Philip J., 25 James st., Newark (7)
Conti, Michael, 280 4th st., Jersey City (9)
Costa, Philip N., 88 E. Front st., Red Bank (13)
Cox, J. Robert, 37 W. Main st., Pennsgrove (17)
Davis, William J., 144 Harrison st., East Orange (7)
Dengler, Henry P., 260 Morris av., Springfield (20)
Fortunato, Joseph F., 224 Van Buren st., Newark (7)
Garfinkle, Abraham, 30 Broad st., Flemington (10)
Gilmour, John R., 144 S. Harrison st., E. Orange (7)
Goldman, Jerome, 220 Oakland rd., Maplewood (7)
Hicks, Alfred M., 65 Park st., Montclair (7)
Holtzman, Michael, 167 Second st., Elizabeth (20)
Kilborn, Melville G., 7 Gilbert pl., West Orange (7)

Kiley, John E., 94 Park st., Montclair (7)
Lovett, Irving K., 110 E. Front st., Red Bank (13)
Mangogna, Philip, 241 South 7th st., Newark (7)
Richardson, Arthur H., 60 Orange rd., Montclair (7)
Scott, Karl M., 1616 Pacific av., Atlantic City (1)
Sena, Dominic R., 190 W. Milton av., Rahway (20)
Stoddard, Gordon V., 41 S. Munn av., E. Orange (7)
Strahan, Frank G., 473 Broadway, Long Branch (13)
Tepper, Victor, 2 Parkview ter., Newark (7)
Wiener, Joseph, 601 Bangs av., Asbury Park (13)
Williams, Raymond A., 7207 Atlantic av., Ventnor (1)
Wolf, Frank A., 494 So. Main st., Phillipsburg (21)
Yelin, Gabriel, 635 High st., Newark (7)
Zuck, Arthur C., 22 Broad st., Washington (21)

ASSOCIATE MEMBERS

Gehl, Sidney H., 65 Wolcott ter., Newark (7)
Kallen, Arnold M., 285 Wainwright st., Newark (7)
Rinzler, Elliot, 211 Roseville av., Newark (7)
Schirber, Rene G., 11 Kirkpatrick st., New Brunswick (12)

MEDICAL PREPAREDNESS ACTIVITIES

The following letter from General Hershey, Acting Director of the Selective Service System, informs us of the actions which will be taken by the Federal Government in suits brought against Medical Examiners for local

boards. This information is the result of the conference held with Selective Service officials in Atlantic City, May 21 (see page 316 of the June Journal):

"The National Selective Service System will act as follows:

(1) Request the Attorney General to instruct the United States District Attorney to appear on behalf of the United States Government or to assign a special representative of the Attorney General's office to the case.

(2) Supply expert medical testimony from our own staff.

(3) Request outstanding experts to testify without expense to the individual being sued.

(4) Coöperate in a reëxamination of the registrant if such is deemed desirable.

(5) Do anything else which is within our power to assist in a thorough and

complete presentation in the case in order to make certain that no unjustified claim shall succeed, and

(6) If a judgment is secured, present a bill to Congress and recommend its adoption, looking toward the paying of the judgment by the United States Government.

You are at liberty to advise the doctors in New Jersey and any other persons who are volunteering their time to the administration of Selective Service to this commitment on the part of the national administration of Selective Service."

Sincerely yours,

(Signed) LEWIS B. HERSHEY,
Deputy Director.

MEDICAL SERVICE ADMINISTRATION

FARM SECURITY PLAN

Farm Security Plan is operating smoothly and the coöperation of participating physicians and County Committees satisfactory. However, there were a few instances requiring specific interpretations of the rules. Commonest irregularity was the practice of charging fees not commensurate with the subscription rate paid; for example, a charge of \$2.00 for an office call and \$3.00 for a house call. The Plan will not support such a schedule. Each county committee has agreed that the basic fee allowance will be \$1.00 for office call and \$2.00 for house calls.

In certain months the case load may be so heavy that even this fee may have to be reduced. These subscribers pay \$4500 per thousand patients for medical care. This is much above the amount ordinarily expended by this economic group.

The Board of Governors on June 22 ruled that it would not, except in unusual instances, alter the decisions of the County Advisory Committees. Thus, twice last month, a County Advisory Committee disallowed payment for a specific service. The Board upheld these decisions, but has advised the physicians of their right to appear before their Advisory Committee to explain the circumstances. The appearance of physicians before their County Committees to make a more thorough presentation of their cases will be of great value to the Administration in determining future policies. This work is new to all of us and we have a fixed minimum amount of money available for distribution each month. The County Committees and the Board of Governors want

to assure an equitable distribution of this money.

Present subscription rates will not support payment for mileage. The Board on June 22 adopted the policy that all contracts which have been completed and signed by the subscriber must remain in force for the contract year.

The small residue in the allotment for physicians' fees in May will be retained until the end of the contract year, when it will be used to reimburse for services rendered during months when we have been unable to maintain the \$1.00 and \$2.00 fee schedule.

PLANS 1 AND 2

While progress has not been sensational or dramatic, a large number of responsible industrial organizations are giving our plans careful study.

Many problems must be considered in each organization before the plans are presented or enrollment attempted.

Plan 2, providing for the payment of care during major illnesses, is by far the most promising plan for obtaining volume enrollment.

PLAN 4

The plan to provide payment of house and office care for medically indigent groups has aroused much interest. The Board of one of the largest housing authorities in the State recently approved the plan in principle, recognizing its adaptability to their tenants, and now has the plan under serious consideration.

The Administration urgently requests the active participation of all physicians.

COUNTY SOCIETY REPORTS

ATLANTIC COUNTY

By Sloan G. Stewart, M.D., Reporter

The regular meeting of the *Medical Society of Atlantic County* was held at the Ambassador Hotel on May 9th, 1941, at 8:30 p.m., with the President, Dr. V. Earl Johnson, presiding.

COMMITTEE REPORTS

Dr. Barbash, for the *Broadcasting Committee*, reported on the success of the broadcasts on the evenings of the regular meetings.

Dr. Carrington, for the *Membership Committee*, submitted an amendment to the By-Laws of the Society which would provide for associate membership. After discussion the proposed amendment was returned to the committee for revision.

The Secretary, for Dr. Scanlan, read a report of the *Committee on Insurance*.

Dr. Carrington, for the *Medical Practice Committee*, reported the Committee was meeting with the Draft Board and suggesting remedial measures to those draftees who are rejected.

Dr. Kilduffe submitted a written report of the *Medical Preparedness Committee*.

Dr. Kilduffe also made a written report of the *Telephone Committee*. After much discussion the Secretary was instructed to notify each member to make a request to the Telephone Company to have M.D. follow his name in the classified section of the directory.

The Treasurer's report was submitted to the Auditing Committee, Dr. Carrington, Chairman.

ELECTION OF OFFICERS

The following officers were elected:

President, Harry Subin
Vice-President, Robert A. Bradley
Treasurer, David B. Allman
Secretary, J. Carlisle Brown
Reporter, Sloan G. Stewart
Historian, H. L. Harley

Delegates

D. W. Scanlan
D. B. Allman
J. S. Irvin

Alternates

A. Krechmer
George A. Poland
A. M. Smith

Board of Censors: V. Earl Johnson

Executive Committee: Theo. H. Boysen

State Nominating Committee: D. W. Scanlan

Alternate: David B. Allman.

BERGEN COUNTY

Samuel C. Bump, M.D., Reporter

The *Bergen County Medical Society* held its thirteenth annual outing at Bergen Pines, on June 13, 1941. The doctors played baseball, pitched horse shoes and indulged in other sports including trap shooting and archery. Through the efforts of Dr. Morrow, Medical Director and Superintendent of

Bergen Pines, biologic, surgical and hospital supply houses and pharmaceutical companies furnished samples and donated prizes to the doctors holding lucky tickets. After a short business meeting the usual buffet picnic dinner was enjoyed.

The following prizes were awarded:

Trap Shooting—

First prize, stethoscope, Cosmevo Surgical Supply Co.—Dr. F. P. Twinem.

Second prize, Twin Pack thermometer, Bergen County Medical Society—Dr. J. M. Campbell.

Third prize, cake, Continental Baking Company—Dr. F. S. Hallett.

Horse-Shoe Pitching—

First prize, first aid kit, Burroughs Wellcome & Co.—Dr. C. D'Amato.

Second prize, Twin Pack thermometer, Bergen County Medical Society—Dr. M. Sarla.

Third prize, Merck Manual, Merck & Company—Dr. F. C. Forte.

Archery—

First prize, one box golf balls, Anderson Sport Shop—Dr. F. P. Twinem.

Second prize, Twin Pack thermometer, Bergen County Medical Society—Dr. J. W. Demarest.

Third prize, one box cake, Continental Baking Company—Dr. L. B. Whitman.

Door Prizes—

1. Sollox lamp, Hanovia Chemical Company—Dr. A. L. Gramsch.

2. Physician's bag, Becton Dickinson—Dr. P. J. MacLaren.

3. Bouquet of flowers, Beuerleins Sons—Dr. J. W. Demarest.

4. Travel kit, Mennen's—Dr. R. G. Perham.

5. Bottle of Scotch, B. R. Elk & Co.—Dr. V. Farmer.

6. Bottle of Rye, B. R. Elk & Co.—Dr. S. Alexander.

7. Box cake, Continental Baking Company—Dr. B. J. Ellmers.

8. One thermometer kit, Cosmevo Surgical Supply Co.—Dr. B. Witkoff.

9. One sterile tube thermometer, Cosmevo Surgical Supply Co.—Dr. J. M. Coppoletta.

10. One urine test set, Eli Lilly & Co.—Dr. H. D'Agostin.

11. One urine test set, Eli Lilly & Co.—Dr. Sandler.

12. One box Vitamin B Complex, Lederle Laboratories—Dr. L. B. Whitman.

13. One box cake, Continental Baking Company—Dr. S. B. Reich.

14. One box cake, Continental Baking Company—Dr. F. Muller.

15. One box ice cream, Borden's Farm Products, Inc.—Dr. H. R. Mores.

16. One bottle Vi Penta Perles, Hoffman La Roche—Dr. G. Toscano.

17. One ham, Beinecke, Inc.—Dr. F. L. Lombardi.

18. One flashlight, Cosmevo Surgical Supply Co.—Dr. F. P. Twinem.
19. One Twin Pack thermometer, Bergen County Medical Society—Dr. J. W. Demarest.
20. One tourniquet, Cosmevo Surgical Supply Co.—Dr. J. R. Morrow.
21. One Twin Pack thermometer, Bergen County Medical Society—Dr. J. R. Rowe.

CUMBERLAND COUNTY

C. E. Lyon, M.D., Reporter

Dr. W. Sherman Garrison of Cedarville was elected President of the *Cumberland County Medical Society* at a regular meeting of the organization on June 10 at Tall Cedars in Bridgeton. Dr. Garrison was elected to fill the vacancy left by the resignation of Dr. Helen E. Weithaase, who had been elected President on April 8. With Dr. Garrison's elevation to the Presidency, his post as Vice-President was filled by the election of Dr. Edward Thalheimer. (The other officers are listed on page 332 of the June *Journal*.)

A talk on "Roentgenography in Diseases of the Chest" by Dr. J. G. Cohen featured the scientific program of the evening. Resolutions were passed expressing the Society's sorrow at the death of Dr. Van Deusen, ordering payment of the deficit incurred in connection with the extension course, electing Dr. Charles Butcher and Dr. Edward Thalheimer delegates to The Medical Society of New Jersey, and admitting into membership Dr. A. L. Gricco of Vineland and Dr. T. S. Sheppard of Millville.

ESSEX COUNTY

Paul H. Hosp, M.D., Reporter

The Annual Meeting of the *Essex County Medical Society* was held at the Academy of Medicine in Newark on May 8th, 1941. Dr. Harry Comando, President, called the meeting to order at nine o'clock.

Reports were given by standing committees and the following high-lights were noted:

Child Welfare (reported by Dr. Chester Brown): Over 4500 ounces of mother's milk was handled by the Breast Milk Station at the Coit Memorial Hospital.

Membership Committee (Dr. Crecca): Fifty-four members were admitted during the year.

Milk Committee (Dr. Elmer Wherry): The milk condition in Essex County is satisfactory. Essex County now has as pure and safe a milk as any place in the world.

Graduate Education (Dr. Stuart Hawkes): Courses were given during the year covering "Chest Diagnosis", "Fractures", "Biliary Tract Diseases", "Vascular Diseases", "Amputations". Fifty per cent of the physicians who attended the lectures and demonstrations came from outside Essex County. Two participants came from outside the State.

Publication Committee (Dr. H. C. Barkhorn): The Bulletin has grown from 144 pages to 272 pages in the year. It is financially more than self-supporting.

More communications from members would be welcomed.

Public Relations Committee with its five subcommittees were reported by Dr. Royal Schaaf. This committee has promoted public medical forums, "Modern Medicine" in the *Evening News*, and "Timely Medical Topics", also in the *News*. The Speakers' Bureau handled 92 addresses. The course for expectant fathers was a howling success. Many requests for consultation by medical specialists were met. The exhibits enjoyed an attendance of 22,071; the educational moving pictures proved very popular.

Dr. LeRoy Wood presented Dr. Comando, retiring President, with the Past-President's Key. In his presentation remarks, Dr. Wood said it was the symbol of the thanks and esteem of the Society, a token that Dr. Comando richly deserved.

The following officers were elected for 1941-42:

President, Dr. F. C. Weber
President-Elect, Dr. W. W. Cox
First Vice-President, Dr. J. W. Hurff
Second Vice-President, Dr. L. Schneider
Secretary, Dr. M. H. Greffinger
Treasurer, Dr. R. H. Rogers
Reporter, Dr. P. H. Hosp

Councilors: Drs. M. F. Baker, E. W. Erler, T. W. Harvey, O. G. Matheke.

State Nominating Committee: Dr. H. Roy Van Ness (delegate) and Dr. William H. Areson (alternate).

Delegates to State Society: Drs. W. H. Areson, M. F. Baker, H. C. Barkhorn, F. A. Bien, C. W. Buvinger, R. N. Connolly, E. A. Curtis, R. H. Diefenbach, E. A. Flynn, J. I. Fort, A. J. Ganley, W. F. Brady, J. W. Gray, M. H. Griefinger, P. H. Hosp, E. C. Klein, Jr., D. A. Kraker, J. H. Lowrey, O. G. Matheke, P. E. Menk, H. A. Murray, A. G. Pilch, C. F. Rathgeber, Louis Schneider, F. C. Weber, E. L. Wood, Asher Yaguda.

Alternates: Drs. Anthony Ambrose, S. H. Baldwin, C. W. Barkhorn, Joseph F. Barrett, Kenneth Blanchard, G. A. Braun, H. A. Brodtkin, L. W. Brown, E. P. Cardwell, F. F. Carman, F. P. Carrigan, A. R. Chamberlain, C. G. Crane, E. W. Erler, A. O. Godfrey, A. J. Gordon, M. G. Gregory, H. H. Hantman, H. T. Herold, L. W. Hughes, B. M. James, E. B. Lafferty, Anthony Parisi, C. J. Reilly, E. A. Seidman, A. R. Sherman, R. W. Walton, A. W. Wyker.

The *Practitioners' Club of Essex County* held its 53rd Annual Dinner at the Essex County Country Club, May 7th, 1941. More than 180 were present.

Addresses were made by the Reverend Frank S. Mead, who spoke on "What Next?", an interesting talk by Col. Franklin D'Olier, "Experiences of a Recent Trip to England for the American Legion". Tenor solos were rendered by Mr. Donald Dame. George H. Van Emburgh, M.D., was Toastmaster.

The committee in charge consisted of Charles W. Barkhorn, Chairman; Joseph Clarken, M.D.; Kenneth Wheeler, M.D.; Raymond Mullin, M.D., and J. Irving Fort, M.D.

GLOUCESTER COUNTY

Clarence A. Bowersox, M.D., Reporter

The Nominating Committee announces the following recommendations for officers and delegates for 1941-1942:

President, Frederick G. Wandall, M.D., Clayton
Vice-President, Cecil C. Sheets, M.D., Paulsboro
Secretary, Chester I. Ulmer, M.D., Gibbstown
Treasurer, Don B. Weems, M.D., Wenonah
Reporter, Clarence A. Bowersox, M.D., Woodbury
Historian, Dorothy M. Rogers, M.D., Woodbury
Trustee, three years: Henry B. Diverty, M.D.
Censor, three years: Oran A. Wood, M.D.
Delegates to State Medical Society, three years:
Isaac N. Patterson, M.D. Alternate, Joseph F. Hughes, M.D.
Member of Nominating Committee of State Society:
Baxter A. Livingood, M.D. Alternate, Wendell J. Burkett, M.D.
Delegates to County Medical Societies:
Burlington—Henry B. Diverty, M.D., Harry Nelson, M.D., Oran A. Wood, M.D.
Camden—Clarence A. Bowersox, M.D., Dorothy M. Rogers, M.D., Henry B. Diverty, M.D.
Cape May—J. Harris Underwood, M.D., Benjamin G. Broselow, M.D., Henry B. Diverty, M.D.
Cumberland—Wendell J. Burkett, M.D., Louis K. Collins, M.D., Horace M. Fooder, M.D.
Salem—Baxter A. Livingood, M.D., Cecil C. Sheets, M.D., Henry L. Sinexon, M.D.

The President will appoint the following committees: Program, Public Relations, Public Health, Maternal Welfare, Post-Graduate, Medical Preparedness.

MIDDLESEX COUNTY

For an account of Middlesex County's June meeting, see page 373 of this issue.

MONMOUTH COUNTY

Murray Woronoff, M.D., Reporter

The regular meeting of the *Monmouth County Medical Society* was held at the N. J. State Hospital at Marlboro on May 28, 1941. Two talks were presented, one on "Recent Advances in Laboratory Diagnosis" by Dr. William Thompson of the Columbia University College of Physicians and Surgeons in New York, and one on the "Bulgarian Treatment of Parkinsonism" by Dr. James B. Pettis, Clinical Director of the State Hospital at Staunton, Virginia.

Dr. Thompson discussed the limitations on laboratory tests, the accuracy of work done by technicians, and the "gullibility" of physicians in believing too implicitly in laboratory test results.

Dr. Pettis stressed the effect of the Bulgarian treatment (with belladonna) on the mental and emotional symptoms of parkinsonism. His results were dramatized with a moving picture demonstration of patients before and after medication.

Both talks were exceedingly interesting. As usual with meetings at Marlboro, an appetizing collation was served at the conclusion of the scientific program.

MORRIS COUNTY

F. Clyde Bowers, M.D., Reporter

A regular meeting of the *Morris County Medical Society* was held on Thursday evening, May 15th, at the Shonghum Mountain Sanatorium with forty members and several guests in attendance.

The minutes of the April meeting, and the minutes of the Executive Committee meeting of April 22nd were approved as printed in May Bulletin.

Report of Nominating Committee was as follows:

President, D. W. Teller
Vice-President, F. C. Bowers
Secretary, G. J. Young
Treasurer, J. H. Harrington
Reporter, W. M. Judd

Executive Committee: W. B. Gibb, D. J. Geary.

S. Teskey

Delegates to State Convention: J. S. Forbes, S. Teskey

Alternate Delegates: E. McElroy, J. L. Voss, E. T. Carberry, A. O. Hubert, R. A. Eckhardt, W. M. Judd, C. A. Musetto

State Nominating Committee: B. C. McMahon

Alternate: B. G. Sherman

Dr. S. C. Haven told of the founding of Shonghum Mountain Sanatorium. After efforts on the part of Drs. Haven, Mills, Henriques and Livingston Farrand and other medical men of the county to convince the people of the necessity for an institution where tuberculosis could be treated, decided action was finally taken in 1911. People still thought by just walking by a tuberculosis hospital they would contract the disease; that hearing a patient cough was as dangerous as being near an exploding bomb. However, the legislature had passed a law allowing Boards of Freeholders to erect county institutions for "advanced cases", and the Medical Society began putting pressure on the Freeholders.

Meetings were held, a tuberculosis society formed, the assistance of Frank D. Abell, who was then coming into prominence, was secured, and in 1912 plans and specifications made for the erection of a hospital. The freeholders appropriated \$35,000 for a site and building; bonds were sold and later an additional \$30,000 provided. Opposition still continued and the Medical Society was asked for an opinion as to whether confining numerous tuberculous patients in one building wouldn't be dangerous to the community.

In January, 1914, the building was constructed and in June it was officially opened with Miss Helen Butler as superintendent. Half the battle was over, but the cases sent to the institution were all "advanced" and the hospital became known as a comfortable place to die in rather than a place where the disease could be cured or arrested.

The County Medical Society continued the fight. Finally, Dr. Harold S. Hatch, the present resident county specialist, was secured and Shonghum Mountain Sanatorium no longer was considered a "death house" but a real institution where tuberculosis lost its fear and patients were helped and returned to society to take their place in the commercial and industrial life.

Dr. William Booth of Boonton took up the story

from there and related the activities which led to the present addition to the hospital. Dr. Booth told of the many cures and percentage of arrested cases now on record at Shonghum, and how continued efforts are being made to eradicate the disease.

Dr. Samuel B. English, medical director of the state tuberculosis institution at Glen Gardner, was a guest speaker. He mentioned the fine work being done at Shonghum by Dr. Hatch, and of the modern addition which he had inspected early in the evening.

X-ray pictures and the story of tuberculosis surgery were explained by Dr. Paul Geary, who has performed many chest operations at Glen Gardner.

Dr. Geary recalled the early rest methods of attempted cures, which finally led to surgery. Rest, however, he stated, is the prime factor in all means of treatment. Excellent results had come through attacking the germs by surgical treatment of the pulmonary cavity.

The meeting adjourned at 10:30 p.m., and after Dr. Hatch cordially invited members of the Society to inspect the new building at any time, refreshments were served.

OCEAN COUNTY

L. W. Falkinburg, M.D., Reporter

The June 11 meeting of the *Ocean County Medical Society* was held in the Carlton Hotel, in Tuckerton, N. J., and was opened by Dr. E. Dodd, President of the Society. The minutes of the last meeting were read and approved.

The annual report of the Treasurer was then submitted, as well as the report of the Auditing Committee. Both reports were accepted as read.

A short farewell speech was made by out-going President Dr. E. Dodd, in which he thanked the members for their coöperation and urged better attendance at the monthly meetings of the Society. Then the incoming officers were presented to the Society, and short talks were given by various former Presidents of the Society.

The meeting adjourned at 10:30 p.m.

UNION COUNTY

Frederic W. Lathrop, M.D., Reporter

The annual meeting of the *Union County Medical Society* was held on the evening of April 9, 1941, at the Muhlenberg Hospital in Plainfield. Dr. George Knauer, the President, called the meeting to order, and introduced Dr. LeRoy A. Wilkes, Executive Officer of The Medical Society of New Jersey, who spoke briefly of the work of the State Society's executive office.

Mrs. H. V. Hubbard of the Woman's Auxiliary explained the program of the Woman's Field Army for Cancer Control, and distributed pamphlets outlining the project. Mrs. Hubbard asked the Union County Medical Society to appoint representatives to serve on the Executive Board of the Field Army.

A letter from Dr. Norman Scott, Medical Director of the Medical Service Administration, was read announcing that Union County, having passed the

quota of registering 51 per cent of its members as participants in the Medical Service Plan, was now eligible for the operation of the Plan.

Dr. J. M. Carlisle, Chairman of the Industrial Hygiene Committee, reported the intensive work carried out by his committee coöperating with the corresponding State committee during 1940-41, and announced a program of increasing coöperation with local agencies and plant departments.

Dr. G. T. Banker, the Treasurer, read the expenses and income of the 1940-41 fiscal year, and presented the 1941-42 budget. It was announced that Dr. W. E. Boozan and Dr. W. H. McCallion had surveyed the Treasurer's books and certified them as correct. The Treasurer's report and the proposed budget were formally approved by the Society.

The following applicants were elected to membership in the Union County Medical Society: Drs. Dorothea Bender, Phyllis Schaefer, Thomas Higgins, Myra Smith, C. S. McKinley and Edward Yorke. The name of Dr. Domenic R. Sena of Rahway was presented for first reading as an applicant for membership.

The Secretary, Dr. F. W. Lathrop, read the following proposed amendment to Section 1 of Article XV of the Constitution:

"That those members in good standing who enter active military service in the United States Army or Navy be given a leave of absence without payment of County dues for the duration of their service with the Federal Government. However, this member will have to pay the State Society and A. M. A. assessment if he wishes to remain in good standing in those organizations."

Moved and seconded. Passed unanimously.

The following proposed amendment was read by Dr. M. G. Bensley:

Article X, Section 1. "The Executive Council of the Society shall consist of the following: Members of the Board of Censors, Members of the Board of Trustees, Junior Past President, Officers of the Society, and two members of the Medical Staff of each General Hospital in the County to be elected by the respective boards."

A brief discussion followed. No action. The proposal will be published in May Bulletin and voted on at June meeting.

The Executive Committee made the following recommendations:

1. *Refund*—County Society to prorate a refund of County dues to those members already called to service in accordance with the length of time the member was in the County Society. Moved, seconded. Carried unanimously.

2. *Return* to Mrs. Warncke dues paid by Dr. Warncke. Moved, seconded, carried.

3. *Chairman* of each committee to be named when the President appoints the committee. Moved, seconded, carried.

4. *Secretary* of Medical Service Bureau to receive \$15.00 per month for extra services required by county work. Moved, seconded, carried.

5. *Postponement* of May meeting to June 11th. Moved, seconded, carried.

ELECTIONS

Dr. Bensley, Chairman, read the ballot of the Nominating Committee.

1. Nominations from the floor: Public Health, Dr. Nittoli. Board of Censors, Dr. Corbusier. Dr. Rose, for 1944 Delegate.

2. Moved and seconded that the ballot be accepted as read with the exception of the three offices for which the candidates were nominated from the floor and that these three offices be voted on in regular order by written ballot. Carried.

3. *Drs. Reiner, Carpenter and Brokaw* appointed as Tellers. During the count, *Dr. Schlichter* reported the delay of the Medical Defense program due to the failure of many physicians throughout the counties to return the A. M. A. Questionnaires.

4. *Dr. Knauer*, as retiring President, gave a brief address noting the rapid progress of coöperation between the Medical Society and various lay groups which has brought the physician into a wide scope of activity. A great part of this is shown in the intense program of the Medical Defense work.

The tellers announced election of the following officers for 1941-42:

President, Lorrimer Armstrong
First Vice-President, George Seymour
Second Vice-President, Elton W. Lance
Secretary, Frederic W. Lathrop
Treasurer, George T. Banker
Reporter, Edward G. Bourns

Trustee: Watson B. Morris (1944)

Board of Censors: Thomas J. Walsh (1946)

Public Health Committee: Herschel S. Murphy (1946)

Public Relations Committee: William H. McCalion (1946)

Legislative Committee: W. J. Hallock (1946)

Scientific and Literary Committee: James M. Carlisle, J. J. Labow, D. Spivack

Medical Service Bureau Committee (1945): L. Baron, E. J. Hackett, C. G. Hanson, DeHart Krans, T. J. Minella, John A. Quinn

Delegates to State Convention (1942):

State Nominating Committee, C. A. Brokaw

Alternate, Norman W. Burritt

Delegate (1942): George Knauer

Alternate (1943): H. C. Stillwell

Delegates (1944): E. S. Krans, T. J. Walsh, R. P. Blythe, L. Armstrong, C. C. Carpenter, F. W. Lathrop, A. Rose, E. Stein

Alternates: J. E. Runnells, R. Cantini, L. G. Beisler, J. J. Labow, L. S. Wegryn, H. Bloch, E. J. Pourns, G. W. H. Horre

Dr. Armstrong accepted the chair from *Dr. Knauer* and closed the meeting with a few words following the motion for adjournment.

Fall Outing

E. G. Bourns, M.D., Reporter

The regular Fall outing of the *Union County Medical Society* was held on June 11 at the Plainfield Country Club with approximately 80 members present. Most of the members came early enough to engage in some very select golfing but unfortunately the resultant scores spoke more for enthusiasm than for accuracy. In fact, several of the late arrivals complained rather testily of the pall of dust hanging over the course and club house.

Two "kickers" tournaments went along very well, one run by the committee and one by the club professional. An intriguing assortment of prizes had been collected by that canny Scot, Jim Carlisle, and these were given out at the end of the evening. A series of door prizes also served to enhance the interest of the occasion. Following a very delicious chicken dinner, a short business meeting was held. Matters concerning the Fall Clinical Conference were discussed by Dr. Charles Robbins; Medical Preparedness by Dr. C. H. Schlichter; Medical Service Administration by Dr. Norman M. Scott.

Prizes were given by the following firms: Rich Drug Co., Newark; Wm. S. Merrill Co., Cincinnati; Bilhuber-Knoll Corporation, Orange; Wm. H. Tegeler Pharmacy, Audubon; Hoffmann-La Roche, Nutley; Scharfenberger's, Elizabeth; Lissco, Newark; Merck & Co., Rahway; John Wyeth, Philadelphia; Dudley Miller Pharmacy, Plainfield; Mead Johnson & Co., Evansville, Ind.

Following are the lucky doctors who won the gifts: Dr. S. H. Carsley, Dr. A. M. Paulson, Dr. C. A. Hoffman, Dr. C. H. Finke, Dr. N. B. Stanton, Dr. J. J. Flanagan, Dr. R. A. Gregory, Dr. M. L. Griswald, Dr. E. H. Doggett, Dr. George Knauer, Dr. Phillip Owen, Dr. E. P. Darlington, Dr. E. J. O'Brien, Dr. M. T. Weisman and Dr. J. E. Runnells.

Incidentally a word of cheer for those accustomed to gather at the wailing wall at the 19th hole—we produced one gross score of 130! Can any other County Society beat that?

SUMMIT MEDICAL SOCIETY

Reported by E. H. Macpherson, M.D., Secretary

The regular monthly meeting of the *Summit Medical Society* was held at Overlook Hospital on May 27. Dr. Steuart, the Vice-President, presided.

Dr. Joseph Echikson of Newark gave an excellent presentation on "The Diagnosis and Treatment of Kidney Conditions". He spoke of the great improvement he observed in Indianapolis on patients with hypertension and chronic nephritis through the new "inhibitor substance" being used by Dr. Page and his co-workers. At present, many technical difficulties must be overcome before it can be made available to the medical profession.

There was much discussion of this subject.

Following the meeting a collation was served.

THE BULLETIN BOARD

Dr. and Mrs. Wells P. Eagleton have donated to the Academy of Medicine of Northern New Jersey a fine brownstone-front mansion adjacent to the Academy's present property. Dr. and Mrs. Eagleton made the gift "to provide a place where doctors may be free to discuss the medical aspect of any public question".

New Jersey will play host to the American Public Health Association when this 70-year-old organization holds its annual meeting in Atlantic City October 14-17. This promises to be an especially inspiring meeting, and physicians interested in venereal disease, mental hygiene, communicable diseases, industrial medicine, dietetics, epidemiology and maternal and child health are urged to make plans now to attend this meeting.

Splints suitable for patients who have had infantile paralysis may be secured free through The National Foundation for Infantile Paralysis, 120 Broadway, New York. Physicians should write to The Foundation for a copy of the booklet "Splints: Their Distribution and Use", which includes instructions concerning the procurement of free splints.

Hypertension and other cardiovascular diseases will be the theme of the Graduate Fortnight of the New York Academy of Medicine, which will be held October 13-24, 1941. The project includes discussions, clinics, demonstrations, speeches and exhibits. A complete program may be secured by addressing Dr. Mahlon Ashford, New York Academy of Medicine, 2 East 103rd Street, New York City.

The U. S. Department of Labor, the Illinois State Department of Public Health and the University of Chicago are sponsoring a four weeks' course in Obstetrics this fall. The only cost to the doctor taking the course is \$25.00 for room and board. Inquiries should be addressed to the Department of Obstetrics and Gynecology, 5848 Drexel Avenue, Chicago, Illinois.

The American Congress of Physical Therapy will hold a scientific and clinical session at the Mayflower Hotel, Washington, D. C., during the first five days of September, 1941. Included in the program will be a symposium on poliomyelitis and practical demonstrations of physical therapy equipment. A complete program may be obtained from the American Congress of Physical Therapy, 30 North Michigan Avenue, Chicago.

The second American Congress of Obstetrics and Gynecology will be held in St. Louis, April 6 to 10, 1942. The program appears to be exceptionally interesting. For further details write to the Con-

gress of Obstetrics and Gynecology, 650 Rush Street, Chicago, Ill.

The nation's hat industry has agreed to eliminate poisonous mercurial compounds from the manufacture of fur felts after December 1, 1941. According to the U. S. Public Health Service this will remove one of the oldest and most serious health hazards to workers. The agreement represents a voluntary decision of both the employers and the unions in the hatting industry.

Physicians or hospitals interested in obtaining the services of Medical Technologists can best determine the qualifications of candidates by ascertaining if they are registered with the Registry of Medical Technologists of the American Society of Clinical Pathologists. For many years leading medical organizations have considered this Registry the national authority for the registration of Medical Technologists.

Present requirements for registration necessitate two years of college, as well as training in an approved school for Medical Technologists. The schools are investigated and evaluated by the Council on Medical Education and Hospitals of the American Medical Association.

The Registry has moved its headquarters from Denver, Colorado, to Muncie, Indiana, and is now operating under the direction of Dr. Lall G. Montgomery, who is the pathologist at the Ball Memorial Hospital.

How many people have syphilis? An interesting booklet on this subject may be secured by writing to the American Social Hygiene Association, 1790 Broadway, New York City. Ask for the "How many people have syphilis" pamphlet written by Dr. M. DiMario and Dr. Charles W. Clarke.

A short, intensive and full-time course in Electrocardiography is being given from August 18 to August 30, 1941, by the Michael Reese Hospital in Chicago. Interested physicians should write to the Cardiovascular Department of the Hospital at 29th and Ellis Ave., Chicago, Illinois.

The next meeting of the New Jersey Gastro-Enterological Society will be held at the Academy of Medicine in Newark on the evening of Monday, October 6, 1941. Physicians interested in attending or taking part in this meeting will communicate with Dr. Hyman Goldstein, 1425 Broadway, Camden.

The New Jersey Society will play host to the National Gastro-Enterological Association in Atlantic City next Spring.

BOOK REVIEWS

AVITAMINOSSES; the chemical, clinical and pathological aspects of the vitamin deficiency diseases. By Walter H. Eddy, Ph.D., and Gilbert Dall-dorf, M.D. 2d ed. Pp. 519. Baltimore, Williams & Wilkins Co. 1941. \$4.50.

Those seeking a less prejudiced and more authoritative discussion of vitamins than can be found in the omnipresent proprietary brochures will find this manual very helpful. The book considers the field from the clinical, chemical, and pathologic points of view with the avowed purpose of being "useful not only to the tyro but also to those whose experience is strictly limited to the bio-chemical or clinical aspects * * *" Obviously to reach such a broad audience, the authors must include much material in these five hundred pages. The arrangement, however, is such that each group will easily be able to cull what it seeks, and the authors are to be complimented on the balance which they give to such a welter of material.

For the clinician, the descriptions of the deficiency diseases are excellent while the chapters on animal deficiencies and oxidation-reduction will seem superfluous. The chapter and bibliography on "Vitamins and the Infectious Diseases" is especially good. Procedures for the various laboratory tests and a table of the vitamin content of foods are compactly given.

EDGAR BRAUN, M.D., Newark.

ELECTROCARDIOGRAPHY IN PRACTICE. By Ashton Graybiel and Paul D. White. Pp. 319 with 272 illus. Philadelphia, W. B. Saunders. 1941. \$6.00.

The mating of two such excellent students and teachers as Drs. Graybiel and White could not help but result in a book which is outstanding in its field. The illustrations, though mostly diagrammatic, have been so well done that this deficiency may well be forgiven. The legends are so clear, concise and instructive that they teach almost without effort. Particularly do I wish to stress the exhaustive manner in which the chest leads, coronary disease, and the newer work on *cor pulmonale* and *pericarditis* have been handled.

This is a most useful handbook for the progressive doctor.

A. E. PARSONNET, M.D., Newark.

ROENTGEN INTERPRETATION. By George W. Holmes, M.D., and Howard E. Ruggles, M.D. 6th ed. Pp. 364. Philadelphia, Lea & Febiger. 1941. \$5.00.

Since its first edition in 1919, this has been one of the best books in English on diagnostic roentgenology. The present sixth edition, revised and brought up to date by Dr. Holmes (Dr. Ruggles died on December 29, 1939), maintains the highest standard.

The work should be in every physician's library and it is essential that every roentgenologist have a copy of the latest edition. It is a practical aid

for roentgen interpretation. The essentials are given clearly and concisely and a comprehensive list of references appears at the end of each chapter for those who wish further information. The present edition contains new subjects and there are discussions on bone changes due to glandular dysfunction, body section radiography, esophageal varices and gastritis. Sixty new subjects are found in the sixth edition in comparison with the fourth. The chapter on fluoroscopic technic should be carefully studied by the increasing number of practitioners who do their own fluoroscopy.

The book cannot be praised too highly.

W. J. MARQUIS, M.D., Newark.

CARDIAC CLASSICS. By Frederick A. Willius and Thomas E. Keys. Pp. 858. St. Louis, C. V. Mosby Company. 1941. \$10.00.

This is one of those books that attests to the fact that American medicine is growing up; it is another in the series of History of Medicine volumes that should be owned by everyone interested in this most fascinating of subjects. The ground work done by de Kruif, Riesman, Garrison, Major and others is carried on by Willius and Keys in a fashion that can only be commended.

The volume has been carefully planned and the publishers evidently spared no effort to have the format, illustrations and printing of it in keeping with the dignity of the subject handled.

This outstanding work should be on the shelf of every doctor's library, because it will not only give him a depth of background, but also an inspiration and desire to go forward whenever his spirit lags.

A. E. PARSONNET, M.D., Newark.

STRANGE MALADY: the how and why of being allergic. By Warren T. Vaughan. New York, Doubleday, Doran. 1941. \$3.00.

Strange Malady is a timely and welcome addition to man's knowledge of a much discussed but little understood subject.

In tracing the transition of allergy from the stage of nebulous concept to that of a definite diagnostic entity, Dr. Vaughan has contributed much to both the medical and lay reader's understanding of a difficult subject.

The many charts and the break-down of the medical terminology to the Latin and Greek roots and their equivalents goes far toward simplifying what would otherwise be a difficult problem of assimilation for the average reader.

Dr. Vaughan's practice of using case histories, general medical history and humorous anecdotes interchangeably is decidedly successful in keeping the reader constantly interested, whereas ordinarily, in a semi-technical book the tendency is to take it as one would his medicine, a little at a time.

This book should prove equally popular with doctors and laymen. Allergy being so universal, it should become an even more engrossing theme than the proverbial operation.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XIV

July, 1941

No. 7

FAILURE to find tubercle bacilli in the sputum, even after repeated examination of successive specimens, is no justification for ruling out the possibility of tuberculosis. Least certain of the several methods commonly used is the staining of the direct smear of the untreated sputum. One supplementary method is to examine the stomach washings for tubercle bacilli especially in the case of children who are likely to swallow the sputum. Roper and Ordway advocate its wider use for adults and offer impressive evidence of its value. Abstracts of their article follow:

GASTRIC LAVAGE IN ADULTS

The examination of fasting gastric contents by smears for tubercle bacilli, first reported in 1898, proved unreliable and the need for culture and animal inoculation was demonstrated. Since 1927 numerous articles have been published regarding this procedure in juvenile tuberculous patients. More recently the test has been used on adults.

This report presents the findings obtained by guinea pig inoculations of fasting gastric contents of tuberculous and non-tuberculous patients. By the addition of this procedure to the usual methods, recovery of tubercle bacilli in tuberculous patients was practically doubled.

The studies were carried out at the Metropolitan Life Insurance Company Tuberculosis Sanatorium, during a three-year period in which approximately 1,000 patients were admitted, of whom 135 were diagnosed as having active pulmonary tuberculosis and the remainder were considered to be non-tuberculous. This afforded opportunity for using controls.

Since 1929 the percentage of minimal cases admitted has almost trebled; in patients with moderately advanced disease it has decreased slightly and in those with far advanced involvement it has declined to one-third the former figure. Yet, the percentage of positive sputum cases has fallen despite the more frequent usage of animal inoculation (from 45.2 per cent in the period 1926-28 to 34.8 per cent in the period May 1936-May 1939).

Of the 135 tuberculosis patients of the present study, 34.8 per cent gave positive recovery by sputum examinations alone. The addition of gastric lavage almost doubled this percentage, namely, 63 per cent. (Tables of the findings are described in detail.)

Sharp distinction is made between sputum and fasting stomach contents. Sputum refers to that bronchial secretion which is actually expectorated by coughing or clearing the throat. The gastric specimen contains that bronchial secretion which has gained entrance into the pharynx and has subsequently been swallowed. Gastric lavage was initially employed in children because of their inability to expectorate. By means of this same test in adults, many positives are obtained among those whose efforts to raise sputum are unsuccessful, as well as in many of those producing unsatisfactory or negative sputum.

Sputum produced by the tuberculous patient may contain tubercle bacilli one day and none on the next. The same variability occurs with gastric washings. Stiehm recommends that the test be given on each of three successive mornings.

The test is of assistance not only in the diagnosis but also in the management of the tuberculous patient. After years of treatment the sputum may disappear or become negative, while the gastric contents still exhibit virulent tubercle bacilli.

The procedure of obtaining the gastric specimen causes only slight discomfort to most persons and is not harmful; on the other hand, repeated forceful voluntary efforts to expectorate are uncomfortable and may be harmful. The importance of proving or disproving the clinical and/or roentgenological diagnosis of pulmonary tuberculosis is obvious; and of equal significance is the conclusive demonstration of the subsequent disappearance of tubercle bacilli from the bronchial secretions of tuberculous patients under treatment. Knowledge of these facts is of sufficient import to

warrant and justify the use of gastric lavage whenever it is indicated by the absence or negativity of sputum.

Gastric Lavage in Adults With Pulmonary Tuberculosis by Wm. H. Roper and Wm. H. Ordway, Amer. Rev. of Tuber., Apr., 1941.

OF what value is pneumothorax in patients of middle age? Numerous studies of the results and complications attending artificial pneumothorax have been made but these have nearly all been concerned with patients between the ages of fifteen and thirty-five. Our actual knowledge of the precise merits of pneumothorax in patients over forty is still meager. For that reason a study made of World War veterans in whom pneumothorax was instituted merits attention.

PNEUMOTHORAX IN PATIENTS OVER FORTY

A survey was made of 431 white World War veterans in whom pneumothorax was instituted or attempted after they had passed their fortieth birthday, during a five-year period beginning January 1, 1935. Every one of the patients had a positive sputum and a roentgenographically demonstrable cavity at the inauguration of his collapse program. Eighty-one per cent had far advanced disease; 19 per cent had moderately advanced lesions. The disease process was unilateral in 49.3 per cent and bilateral in 50.7 per cent. Fourteen per cent had at least one cavity whose diameter exceeded 4 cm. The average age was slightly under 44 years—7 per cent were over 50. The duration of the patients' tuberculosis prior to the attempted induction of pneumothorax ranged from one month to 18 years.

Patients with apparently permanent closure of the cavities and conversion of the sputa were classed as "Successful" and these numbered 92, or 20.2 per cent. The "Unsuccessful" numbered 48.7 per cent and the "Impossible" 31.1 per cent. The various complications of artificial pneumothorax occurred with no greater frequency than among younger patients. Death was due directly to the complications of pneumothorax in 5 patients. Sixteen of the patients who died had pure tuberculous empyemata, though it is difficult to estimate the degree in which the presence of intrapleural pus contributed to these deaths, for in all cases the pulmonary lesion was actively progressive. Including these 16 cases, the fatalities consequent to complications would number only 21 or 4.9 per cent of the patients treated, about what may be expected in general.

The shorter the time the patient has been ill and the less extensive his lesion, the greater the chances

for the success of the therapy and the smaller the probability of occurrence of empyema. Closure of the cavity is effected earlier in patients whose disease history has been brief, though pleural effusions (a complication of little significance in most cases) are more likely to supervene in persons who have had tuberculosis only a short time.

The time interval of cavity closure and sputum conversion varies directly with the patient's age; most of the pneumothoraces became successful in the latter half of their first year. It seems advisable, therefore, to maintain pneumothoraces of doubtful efficacy for a longer time in persons over forty than would be wise in younger patients.

Bilateral pneumothorax, properly administered in carefully selected cases, is well tolerated and ordinarily occasions no marked respiratory embarrassment. The surgical division of pleural adhesions is necessary to the completion of the collapse in a large number of persons in the fifth decade, just as it is in younger patients.

Weighing the results and the complications, the authors conclude that artificial pneumothorax is of distinct value in the treatment of patients over forty. It is not as effective as in younger persons, but neither is any other therapeutic measure. Thus far it appears that artificial pneumothorax is enduring in its effects in persons over forty, but final conclusions cannot be drawn until most or all patients in the successful group have been observed for a sufficient length of time after reexpansion to permit accurate estimation of the lasting effectiveness of their pneumothorax.

Artificial Pneumothorax in Patients Over Forty by Sidney Diamond and Hubert T. Ivey, Amer. Rev. of Tuber., Apr., 1941.

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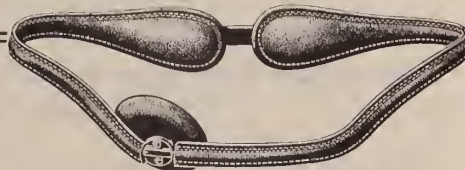
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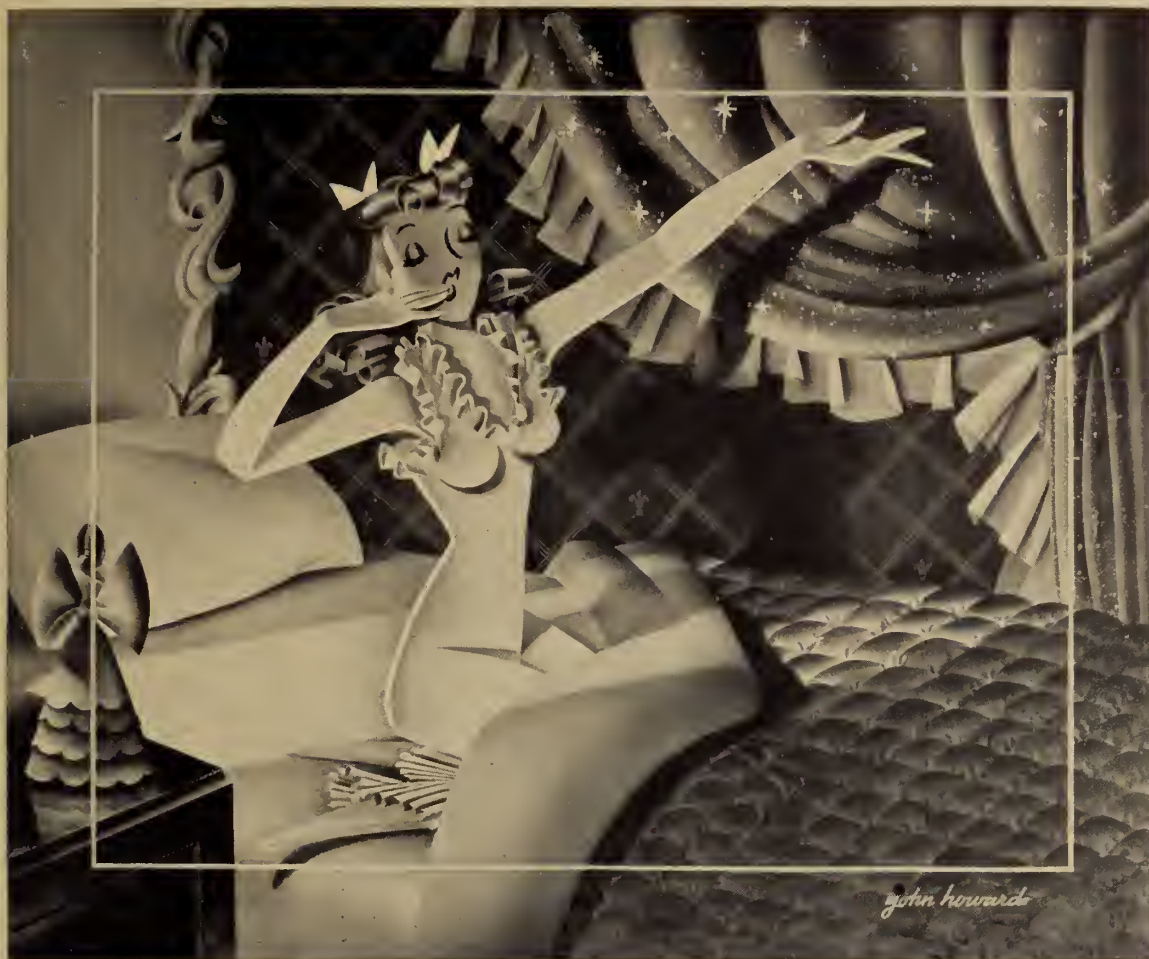
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Roster of Officers on Advertising Page III

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143 EAST STATE STREET
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Sodium chlorid	2,010.48	8,594.84	4,233.14
Potass. bromid	9.23	160.00	13.90
Potass. iodid	1.10	4.80	1.36
Sodium sulphate	None	None	None
Sod. metaborate	Trace	None	Trace
Sodium nitrate	Trace	Trace	Trace
Sodium nitrite	Trace	Trace	Trace
Sodium bicarb.	2,213.78	424.71	1,331.15
Calcium bicarb.	1,829.14	3,380.84	2,519.74
Barium bicarb.	16.67	25.65	25.00
Strontium bicarb.	Trace	Trace	Trace
Ferrous bicarb.	9.94	40.07	5.86
Magnes. bicarb.	753.89	2,244.88	1,186.57
Alumina	7.14	4.98	6.37
Silica	19.40	14.40	12.80
Total	7,284.00	15,808.30	10,130.48

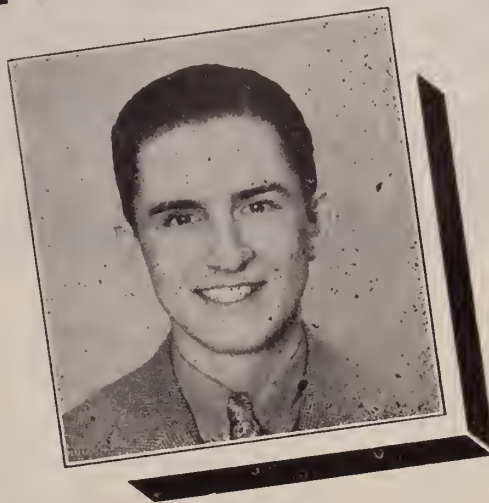
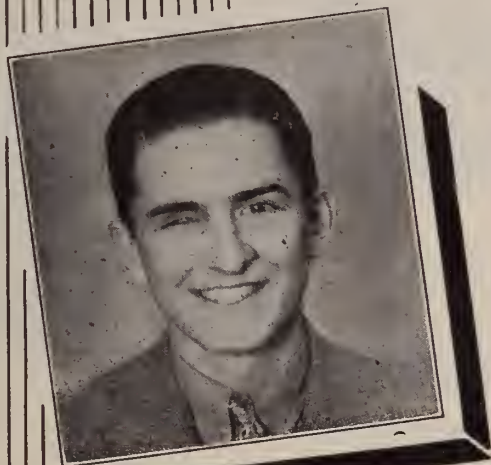
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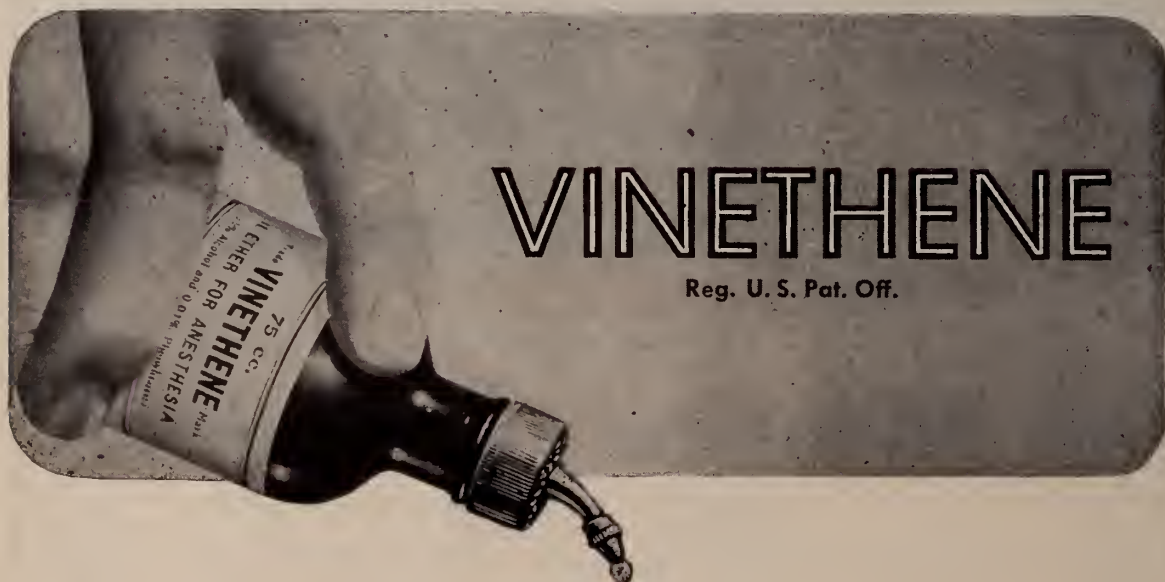
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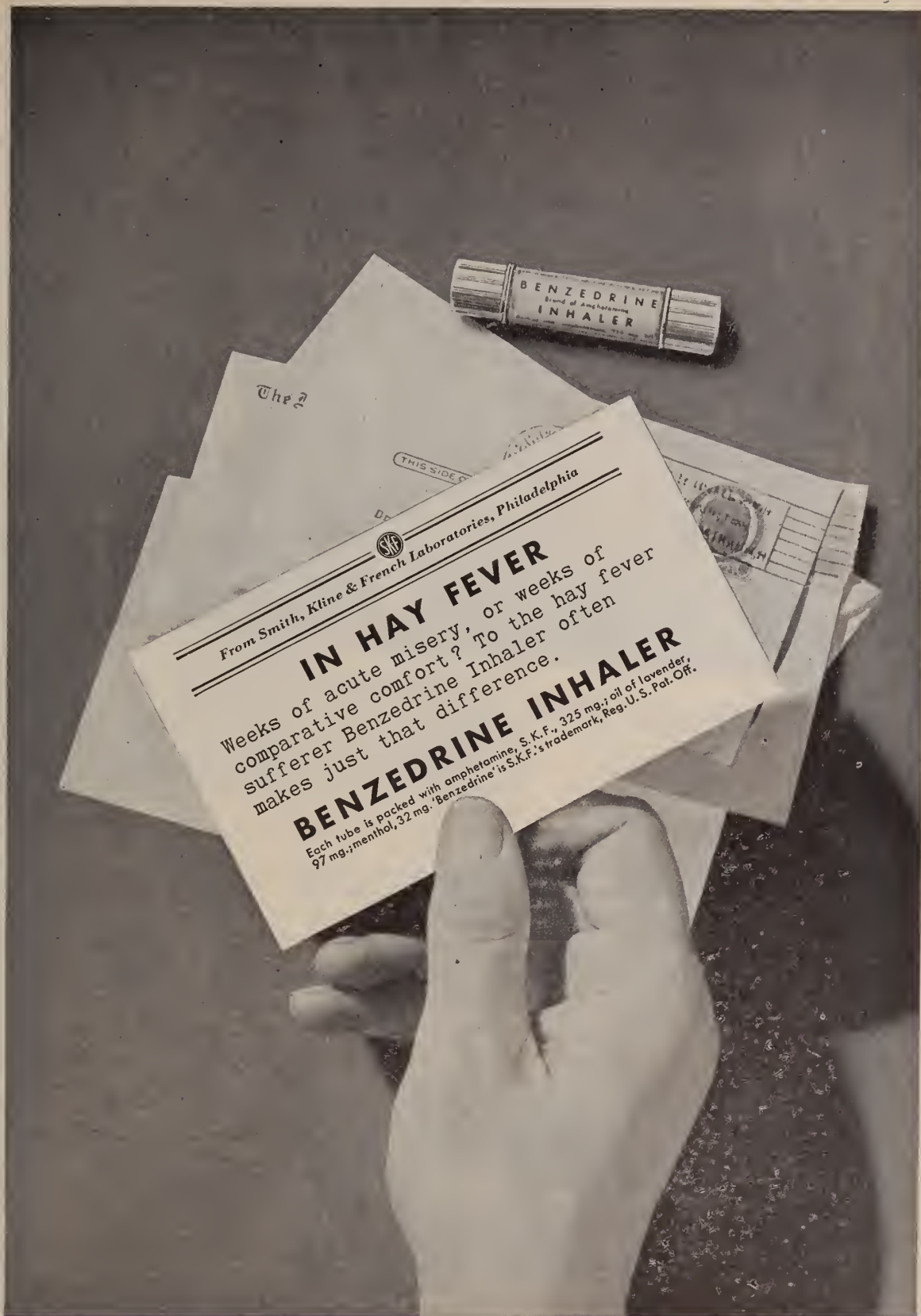
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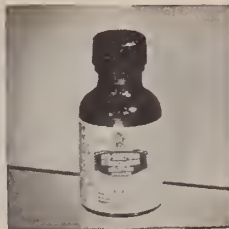
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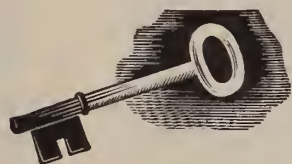
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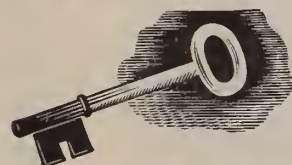
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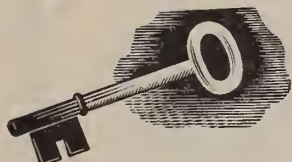
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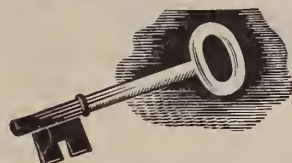
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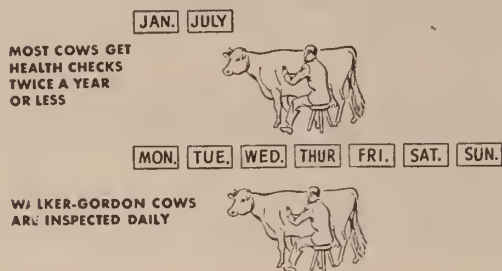


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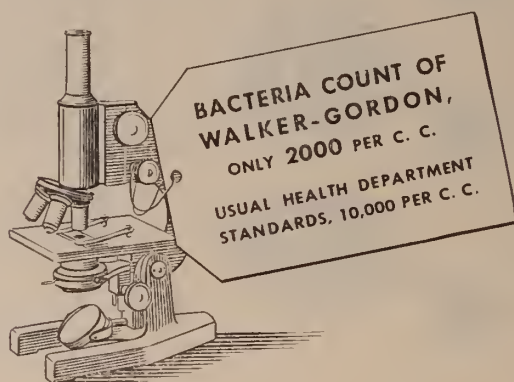
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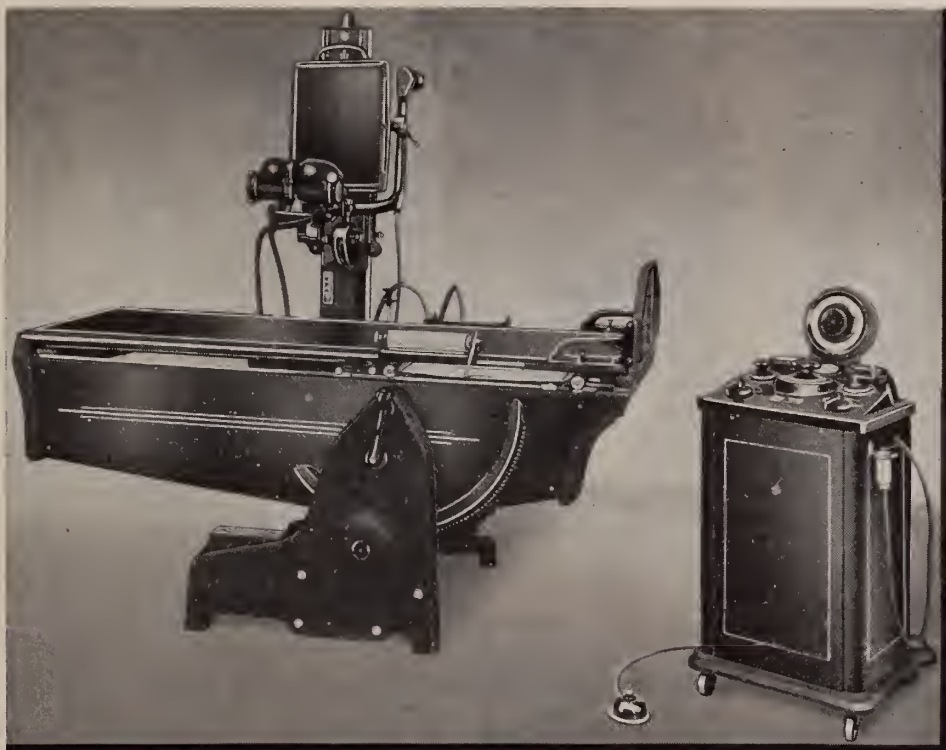
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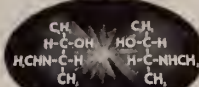


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THE TRANSACTIONS

With this issue of *The Journal* each member receives an abstract of the 1941 TRANSACTIONS OF THE MEDICAL SOCIETY OF NEW JERSEY. Since this illuminates the entire year's work, it should be read carefully by every member interested in the scope, function and activities of his organization.

The TRANSACTIONS describe only the business activities of the Society and do not include the scientific program. The medical papers read in Atlantic City last May were reported on page 316 of the June *Journal*, and many of these papers will be published in full in future issues of *The Journal*.

To read the TRANSACTIONS intelligently it is advisable to have for reference a copy of the May *Journal* in which the Annual Reports are listed in detail. The index to these reports is on page 211 of the May issue. The action taken on them by the House of Delegates will be found in these TRANSACTIONS.

Members, we think, will be particularly interested in the discussion of the resolution on the military status of women physicians, on standards for psychiatrists, and on the proposal to adjust the dues of members in military or naval service. These discussions and actions can be found readily by looking up the appropriate items in the index on the first page of the TRANSACTIONS.

The Treasurer's report is certainly worthy of the attention of our mem-

bers. This is given in detail with an analysis of assessment by counties and by items of income and expense.

A unique feature of this year's meeting was the General Anniversary Session at which the aims and activities of New Jersey agencies concerned with public welfare were reviewed and their relations to The Medical Society of New Jersey described. A full verbatim transcript of the proceedings is available for consultation at the Executive Offices.

FOURTH ANNUAL FALL CLINICAL CONFERENCE

December 3, 1941

ELIZABETH, NEW JERSEY

HOST: UNION COUNTY MEDICAL SOCIETY

THE HIDDEN ASSET

Leafing through a hospital report, physicians must sometimes make wry faces as they read in the list of "items received," such donations as "One Hundred dollars from John Smith" or "Flowers for the Solarium from Mary Brown." The wry faces are not due to any objection to the publicizing of such donations; but rather because the greatest contribution the hospital ever receives is somehow not listed in the "income" side of the hospital ledger. The greatest gift, of course, is the personal professional services of the medical staff given as a free contribution to ward and clinic patients. It would be a refreshing experience to see some hospital soberly list in its column of donations an acknowledgment such as "Services in clinic rendered by Dr. Black conservatively estimated at \$1500" or "Ward operations performed by Dr. Jones valued at least at \$10,000."

The services of the doctor are unconsciously or consciously omitted in hospital bookkeeping statements and hospital publicity. To be sure, in some reports a footnote announces that "The Board is grateful to the members of the medical staff for its co-operation" or something like that. But nowhere does it appear that the services of these doctors represent the paramount donation, equivalent to about 86 per cent of the gross hospital income. Indeed, the fallacy of so-called "free services" is carefully maintained. The doctors work gratis, therefore the work is given "free" to the patient and the cost need not appear in the hospital books. In a larger sense, of course, there are no "free" services. Even the water you get

for your radiator in a service station is not really "free". It is an expense item, just as is the printing cost on a "free booklet" you receive through the mail. Someone pays for it.

So with "free medical services". The doctor "donates" or "gives" the service just as surely as the Ladies' Guild "gives" the flowers for the solarium, or just as surely as the other contributing patrons give cash to the hospital's endowment fund.

The services of the medical staff constitute a huge hidden asset not appearing in the hospital's books. How huge, any doctor can roughly calculate by finding the average clinic patient-load; the daily average ward census; and allowing a reasonable fee for the medical attendance, compute the dollars-and-cents value of the services rendered by the staff. Incidentally, the ordinary layman too often firmly believes that doctors *are* paid by the hospital for working in wards and clinics, and assumes thus that the medical profession is the beneficiary of taxed funds or private welfare contributions. The enlightenment of the public on this point would appear to be the job of the hospital authorities and Organized Medicine.

In our thinking and talking about the distribution of medical care, would it not be better—and more accurate—if we doctors, at least, abandoned the phrase "free medical services" and replaced it with "services donated by physicians"? At least some light would thus be thrown on this important hidden asset of the hospital.

THE PERIODIC HEALTH ASSAY

Intelligent adults sometimes go to their family doctors for a periodic health assay, only to be teased out of the office with the casual remark: "Oh, you're all right". No serious effort had been made

to determine whether the statement was true. The physician just could not be bothered doing a "routine" examination on an apparently normal adult.

It is hard to imagine any practice more

detrimental to the public and to the profession than this. As a group we talk much about the importance of early diagnosis in preventing disease. Will we, as individuals, scorn to put that into practice? In terms of public health, the periodical health assay would be a tremendous boon. In terms of benefit to the individual practitioner, it is a way of strengthening physician-patient relationship and demonstrating medical leadership.

Nor is a physical examination the Alpha and Omega of the Health Assay. For the examination, it is a good idea to use the special "complete physical examination form," obtainable from your Executive Office at only 75c a hundred. But the examination is not enough. The patient expects his doctor to advise him seriously on exercise, diet, living routine. The patient expects the doctor to plumb the medical history a little more profoundly than can be done merely by recording a list of operations and illnesses. The patient expects something more than a quick look at the tongue or a 15-second pulse count.

Since a person coming in for a physical examination usually has some health-worry in mind, he is likely to demand a "verdict". What is my life expectancy? Would it be safe for me to undertake a new and arduous business project? In answering this kind of question, the doctor is not expected to be an infallible prophet. Indeed he would be unwise to commit himself dogmatically. Certainly to take a blood pressure and pound a chest, and then to say: "Why you'll live to be 70!" is to tempt the fates. But the doctor can give the patient an honest, frank opinion, based on his best judgment, hedged in with the contingencies made necessary by the imperfections of modern scientific knowledge. No patient can expect more. No doctor should offer less.

Promotion of the Periodical Health Assay is a golden opportunity for a medical triple play: a service to the individual patient; a help to the individual practitioner; and an elevation of the standing of the entire medical profession.

MEDICAL NEWS

"Medicine is the only profession that is muzzled. It is muzzled by itself." So writes Waldemar Kaempffert, Science Editor of the New York Times. Mr. Kaempffert continues with words that should be read by all doctors: "There is the utmost freedom of speech, thought and expression among chemists, physicists and engineers, but not among medical men. We have the utmost difficulty, not in getting information, but first hand information of the kind we think is news. We can't get at the man who is making a discovery. The result is some papers resort to subterfuges."

"Medicine" continues Mr. Kaempffert, "is also the most pretentious of all the professions and the least scientific. It

gives itself far too many airs. It gives itself airs because it has what it calls 'ethics'. Physicians tell us 'We deal with human life. What we say, therefore, must be very cautiously phrased and we cannot step out before the public quite so openly as engineers.'"

"Gentlemen, that is not so. The man who designs a block signal system for the New York Subway is responsible for one billion or more lives every year. His signal system must not fail. The responsibility for human life of a chemist or an engineer is fully as great as that of a medico. So I am not at all impressed when medical science says to me 'We deal with human life'."

While Mr. Kaempffert is unnecessarily

severe concerning the ethical reasons for a doctor's reticence to publicize his profession, nevertheless the point of view is that of many intelligent laymen and it raises a question that must be answered.

Dr. Malcolm Goodrich, while he was President of the New York Medical Society, said: "Today business, industries and education make efforts to interpret themselves to the public. Organized medicine alone must not remain cloaked in an inscrutability which is sure to be misunderstood."

Here are the horns of the dilemma. If we remain "inscrutable" we shall merit the criticism made by Mr. Kaempffert. If we seek to publicize ourselves, we shall stamp doctors as being unethical, publicity-hungry tradesmen.

The answer seems to be this. While the individual doctor cannot and must not publicize his own qualifications and accomplishments, he can and should broadcast the achievements of the medical profession as a profession and as an

organized body. Advances in modern medicine which will alter the point of view toward organized medicine can be announced with dignity and effectiveness through the Medical Society and the Public Relations Committee. It is sometimes impossible to do this without appearing to give emphasis to individual names, and sometimes our publicity will appear to the scholarly doctor to be too dramatic or too streamlined for the dignity of an age-old profession, but such modernization of publicity techniques is necessary in these high-gearred times. The public understands the language of the commercial advertisements and newspaper headlines; the language of the news reel. It does not understand the Hippocratic terminology or the ponderous phrases of an eighteenth century scholar. We must take our times as we find them.

CHARLES M. ROBBINS, M.D.,
Chairman, Public
Relations Committee.

LEADING THE HORSE TO WATER

Suppose the doctor timidly suggests that some of the "inadequacy of medical care" is due to the fact that, occasionally, people just won't avail themselves of free medical care even when it is offered. The answer would be a snort of indignation. "A sick person refuse free medical care! Nonsense."

But it is no nonsense. Trouble is that this is hard to prove. Yet a recent survey of diabetic and endocrine clinics at Stanford University, where medical service is free, demonstrated that 45 per cent of the patients failed to keep one or more of their clinic appointments. And we all know how the New Jersey and municipal Boards of Health have to wield the big stick to persuade a certain pro-

portion of venereal disease patients to receive medical care regularly.

The point seems to be that the *need* for medical care is not the same as the *demand* for it. We doctors often talk at cross-purposes with the socially-minded reformers who want to broaden the distribution of medical care. They select figures which reflect the demand for care, we point to evidences of fulfillment of the need. They say: umpty-ump per cent of the people have bad tonsils, therefore we need a new method of distributing tonsillectomies. We say that anybody who needs a tonsillectomy and can't afford to pay for one, can get it free. And so it descends to the level of a name-calling contest, when the first requisite should be a good dictionary and an agreement on definitions.

ORIGINAL ARTICLES

RESUME OF THE PRESENT-DAY TREATMENT OF ARTHRITIS

By THOMAS K. LEWIS, M.D., Camden, N. J.

Read before the Section on Medicine of the Annual Meeting of The Medical Society of New Jersey,
in Atlantic City, June 6, 1940.

The importance of joint disease, particularly from the economic standpoint, can be best understood by reference to the findings of the United States Public Health Survey of 1937. Applying the percentages of this spot survey to the population of the nation as a whole, the following figures will be obtained, namely—that in the United States there are 6,800,000 cases of joint or rheumatic disease at a given time; and about 100,000,000 work days are lost in a year.

This places rheumatic or joint disease in *first* place as to prevalence; in *second* place as the cause of partial or part-time disability; and in *second* place as to cause of permanent disability. It must be understood that these figures include all conditions involving joints or rendering joint movement difficult. Even discounting for the inaccuracies both on the part of the investigated, and also on the part of untrained investigators, the picture still remains a serious one.

The functions of the arthritis clinic and the arthritologist should be:

1. Diagnosis in the more difficult cases;
2. Evaluation of new forms of treatment;
3. Research.

Perhaps more than in any other disease sufferers from atrophic and hypertrophic arthritis need to be treated as *patients* rather than as *cases*. It is the opinion of the author that treatment of these two great types of arthritis, with as much assistance by the clinic or by the specialist as the individual case may require, rightfully belongs to the general practitioner, for several reasons:

1. The course of these conditions is always chronic, lasting often for a period of many years, during which time the great majority of

those afflicted are carrying on their daily duties to the best of their ability. The physician in charge should be readily available in order to save loss of time at work and in order to avoid encroachment upon rest hours.

2. In the absence of any specific remedies, or other form of specific therapy, treatment must be altered frequently to meet symptoms and conditions, as they arise, in an effort to keep the individual at work on as many days of the year as is compatible with his best interest; and,

3. Treatment resolves itself into supervision and management that involve the most intimate and minutest details of the patient's life. This necessitates a complete understanding of family, socio-economic, and psychic background which none possesses so well as the trusted family physician.

The most satisfactory classification* is the following:

A. Joint diseases of known etiology.

1. Traumatic; e. g., associated with internal derangement, fractures into joints, etc.
2. Infection; e. g., due to gonococcus, tubercle bacillus, streptococcus, and other organisms.
3. Neuropathic; e. g., associated with tabes, syringomyelia, leprosy.
4. Metabolic; e. g., associated with gout.
5. Constitutional; e. g., associated with hemophilia.
6. Anaphylactic; e. g., associated with serum sickness (and allergy).

* Annals of Internal Medicine, Jan., 1939.

B. Joint disease of unknown etiology.

1. Rheumatic fever.
2. Rheumatoid arthritis (proliferative, atrophic or chronic infectious arthritis).
 - a. Typical.
 - b. Atypical (often called nonspecific infectious arthritis, because the causative bacteriologic agent cannot be demonstrated).
 - c. Spondylitis deformans, Strumpell-Marie or von Bechterew type of rheumatoid arthritis of the spine.
3. Degenerative joint disease (degenerative, hypertrophic, or osteo-arthritis).

It is questionable whether the three subdivisions of rheumatoid arthritis are compatible with the known facts. From observation and reading, it would seem more accurate to speak of rheumatoid arthritis with and without other factors.

GONORRHEAL ARTHRITIS

Gonorrheal arthritis is frequently mistakenly diagnosed as rheumatoid arthritis. There still persists, as the result of the teaching of two decades ago, the idea that gonorrheal arthritis is usually monarticular. As a matter of fact, this condition, we now know, is almost always polyarticular, particularly in the early stages, and quite frequently closely resembles rheumatoid arthritis. Late in the course of the disease, one badly damaged joint may predominate the picture. Tardy recognition of the true etiologic factor in gonorrheal arthritis may result in joint fixation with bad position, for which little can be done. Diagnosis of this condition is based on history, concurrent gonorrhea, the complement fixation test, examination of smears of joint exudate, and blood culture. Lack of history, absence of active gonorrhea, failure to find the gonococcus, and negative complement fixation test do not necessarily rule out gonorrhea as the etiologic factor. From available data, blood culture would seem to be the most reliable test for confirmation of diagnosis.

Treatment of gonorrheal arthritis resolves itself into two procedures:

1. Fever therapy, which is completely curative in 60 per cent to 70 per cent of cases; and
2. Sulfanilamide therapy, which, although giving a much lower percentage of cures, has given many satisfactory results.

In view of the discomfort involved and the loss of time entailed by fever therapy it would seem, in the milder cases, that sulfanilamide might well be tried first and, if not quickly productive of satisfactory results, fever therapy should be instituted without undue loss of time. It might be added, that from the accumulated experience of the profession, sulfanilamide is much less dangerous than was thought during the first two or three years of its use.

ATROPHIC ARTHRITIS

Rheumatoid or atrophic arthritis is most commonly encountered before the age of fifty; but the later decades of life are not immune. It attacks young females rather more frequently than males. It is multiarticular, effects the small joints rather than the large; and produces fusiform swellings which are quite distinctive. There are trophic changes, and muscular atrophy. Subcutaneous nodules are frequently encountered. There is proliferation and inflammation of the synovial membrane in varying degree. The synovial fluid is increased in variable quantity and constituency, in which bacteria may or may not be found. Roentgenologic examination in the well-established case will usually show decalcification of the bones contiguous to the effected joints. However, x-ray study alone, without taking into consideration clinical data, in many cases cannot be depended upon for absolute diagnosis.

Laboratory data are of little or no positive value in helping one arrive at a diagnosis in rheumatoid arthritis. Blood counts, glucose tolerance tests, the saline absorption test, plasma pigments, sedimentation rate, and many other tests have been studied by research workers in their relationship to rheumatoid arthritis, but have not been established as aids in diagnosis.

ETIOLOGY

1. *Focal infection*, the one most constant associated factor, remains yet unproved as the cause of this disease. While the removal of foci has been productive of many startling results, and even apparent cures, yet the bacteria encountered are varied; no one organism or group of organisms has been a constant factor; nor has it been possible to reproduce the disease in animals by means of any of the organisms isolated. Not even the first of Kochs' postulates has been fulfilled. In addition, there are many cases where, even with the most careful investigation, no points of focal infection can be found.

2. *Bacterial allergy* has been studied as a possible cause, but without any convincing results.

3. That a *virus* may be the etiologic factor has been suggested, based upon the fact that virus bodies have been found in the joint tissues by some investigators. While no convincing data has yet appeared, this line of investigation is worthy of much more attention.

4. *Trauma* as the causative factor is definitely out, although it may be a strongly contributing agent in the location of the severer joint diseases.

5. *Disturbed circulation* is found in varying degree in almost all arthritic lesions; yet the consensus seems to consider this factor a result rather than a cause of the disease.

6. *Metabolic change* as an etiologic factor has no corroborating evidence.

7. *Vitamine C deficiency* has been demonstrated by some workers in a high percentage of cases; but its administration in large doses has failed to alter the course of the disease itself, although unquestionably improving the state of nutrition and concomitant colonic disturbances.

8. *Endocrine imbalance* has been given consideration, but as yet there is no conclusive data to warrant its consideration in an etiologic capacity.

9. *Neurogenic* disturbances and emotional upheavals, while frequently encountered in the arthritic patient, have not been proved as causative agents.

In a word, despite the enormous amount of

research work that has been carried on during the past few years, we are still in the dark as to the exact cause of rheumatoid arthritis.

TREATMENT

The treatment of rheumatoid arthritis is in a rather chaotic state, largely because we do not know the cause of rheumatoid arthritis.

1. *Focal infection*, as previously mentioned, unquestionably plays an extremely important rôle in the progress and development of the disease in a large percentage of cases. In other cases it seems to have no part. However, so many striking results and even cures have been observed by the removal of foci of infection that nearly everyone agrees that, early in the management of rheumatoid arthritis, removal of obviously infected tissue is indicated.

On the other hand, radical measures such as removal of all teeth, routine tonsilectomy, colectomy, cholecystectomy and other drastic procedures are falling into disrepute and are generally considered unwarranted unless definite infection has been satisfactorily demonstrated.

2. *Vaccines and bacterial antigens* in some cases seem to give very definite relief, but in many instances they accomplish nothing.

3. *Foreign protein reaction* is discredited by many writers, and warmly supported by others. In our experience, at the beginning of treatment this procedure has often been found to serve effectively in checking the progress of the disease.

4. *Bee venom* and *snake venom* periodically appear in literature, particularly in lay periodicals, as a proposed remedy; but there is no evidence to support their use.

5. *Diets* have been recommended for many years, and are still supported by certain authors. Some of these diets are diametrically opposite, the proponents of each claiming about the same results. From the accumulated evidence one is forced to the conclusion that no dietary measure is in itself curative. However, the very nature of the disease is such that muscular wasting and malnutrition and digestive disturbances are concomitant factors, and must be given attention.

6. *Intestinal therapy*, chiefly in the form of

high colonic douches, is advocated by many; but the consensus seems to be opposed to its routine application.

Again, one must admit that colitis is a frequent complicating condition encountered in the arthritic patient. When present it should, of course, be adequately treated. Injudicious use of cathartics should be avoided.

7. *Vitamins B, C, and D* have been suggested as possible cures for arthritis; but the results of their use have been disappointing in so far as the course of the disease itself is concerned. Based on the hypothesis that atrophic arthritis may be due to faulty calcium metabolism, some workers advocated the use of massive doses of vitamin D; but because of the lack of any demonstrable curative results, the practice has been pretty generally abandoned. Because of the frequency of digestive and general constitutional disturbances in the arthritic patient, diets should be rich with a well-balanced vitamin content.

8. *Drugs*, innumerable, have been used in the treatment of rheumatoid arthritis. None have been proved specific, and none have been proved curative. Many drugs have value in the relief of symptoms and are used with varying results by different men.

a. Simple *analgesics*, such as the salicylates, phenacetine and antipyrine, are of value. The formidable array of new analgesic derivatives should be used with extreme caution until such time as the safety element has been established.

b. *Sulphur*, used much in the past, is waning in popularity, and one hears more about it from the laity than from the profession.

c. *Gold* is still in extensive use and is still in the running after the proverbial ten-year period of trial by error. A number of outstanding men claim satisfactory results from its use. However, accumulated evidence seems not to support the fact that it is a cure.

d. *Vaso-dilators*, such as histamine and choline, have been used, no doubt because of the circulatory disturbances found in the arthritic joint; but no notable results have been reported.

e. *Sulfanilamide* has been tried in arthritis, as in most other ailments, but with discouraging results as a whole. One wonders whether

the favorable results reported in a few instances might not have been in cases of specific infectious arthritis, mistakenly diagnosed as rheumatoid arthritis.

9. *Fever therapy* has been most disappointing.

10. *Climate* seems to play an unimportant rôle, since rheumatoid arthritis is reported from all parts of the world.

11. *Sympathectomy* has given no evidence of producing cures.

12. *Psychotherapy* is of no value in curing arthritis. However, practical psychology is a most important adjunct in the maintenance of good morale during the course of what is usually a long and trying ordeal for the patient.

13. *Orthopedic measures* are frequently indicated; and while we do not hold with the orthopedist that rheumatoid arthritis is primarily an orthopedic problem in all cases, we do advocate the use of orthopedic advice at no infrequent intervals.

14. *Physiotherapy* undoubtedly has a place in the treatment of arthritis; but knowing so little about it, great caution should be observed in its use.

a. *Diathermy* gives relief and benefit in some, but not in all cases.

b. *Massage* for the improvement of muscle tone is of distinct value.

c. Rest and exercise in proper proportion should be nicely adjusted in each case. It is not a matter of rest *or* exercise, but rather a matter of rest *and* exercise in the proper proportions for the individual case.

MANAGEMENT OF RHEUMATOID ARTHRITIS

First—Make an accurate diagnosis. Various clinics have found that 45 per cent of joint cases referred are chronic arthritis of unknown origin (i. e., atrophic, or hypertrophic). When one considers that the clinic cases are usually the well-established chronic joint cases, it is safe to assume that, among the joint disabilities of patients applying to the general practitioner, a much smaller percentage belong to these two types. Many of the specific types of joint disease, when spotted early, are amenable to correct treatment; and when one appreciates the fact that delay in treatment in

the specific types may prolong suffering and result in irreparable damage, the importance of diagnosis becomes apparent.

Second—The diagnosis of rheumatoid arthritis having been established, the physician should take the patient into complete confidence, and explain that the road ahead will be long and trying. At the same time it must be explained that the majority of cases ultimately are arrested, with not too much disability remaining.

Above everything else the patient must be warned against the multiplicity of experimental forms of treatment that find their way into newspapers and periodicals long before their true value has been established. Such free discussion should enhance mutual confidence, and secure that degree of coöperation so necessary in satisfactory management of the case.

Third—Removal of established foci of infection.

Fourth—Trial of foreign protein reaction or vaccines or both in an effort to stem the progressiveness of the disease.

Fifth—The relief of symptoms.

Sixth—Careful attention to nutrition, and the prophylactic care of the gastro-intestinal tract.

Seventh—Detailed instructions as to rest, exercise, forms of diversion, and the amount and kind of work.

Eighth—Alertness as to the necessity or indication for orthopedic consultation.

Ninth—The use of physiotherapy according to indications,—probably only after conference with the orthopedist.

HYPERTROPHIC ARTHRITIS

Hypertrophic, or *osteoarthritis*, is a disease or condition usually occurring after the age of fifty. It appears to be a process of fibrosis of the degenerative type, usually associated with generalized senescent fibrosis, and notably affecting, chiefly, the weight-bearing joints. In it one finds degeneration of cartilage, fibro-osseous degeneration of tendon attachments,

synovial changes, capsular fibrosis, eburnation of subchondral bone, bony overgrowth at the perichondral margins of articulating surfaces, and marginal osteophytic excrescences. Heberden's nodes, long considered as pathognomonic of osteoarthritis, are now doubted by some as having anything to do with the process. Roentgenologic findings alone are of no great value in the diagnosis of this condition because of conflicting opinions as to interpretation. With the existing chaotic state of our knowledge of the pathology, etiology, and clinical picture, it is impossible to provide a clear definition. Out of the maze of contradictory findings and conflicting opinions, certain facts emerge and give us, at least, a working basis for practical consideration. Accepting the statement that all individuals over the age of fifty or sixty have the first (or non-disease) stage of osteoarthritis; and, coupling with that the facts that the weight-bearing joints are chiefly involved, and that obesity and trauma are participants in the production of the symptomatic or disease stage, we are safe in assuming that (1) senescent sclerosis is the basic groundwork, and that (2) trauma is the aggravating cause of subsequent disability.

Relief can be obtained by reduction of excess weight, by the readjustment of working conditions to remove strain from tortured joints, orthopedic contrivances for the support of weakened weight-bearing joints, and in some cases operative procedures, to improve joint mobility.

From this rather gloomy survey it becomes immediately apparent that the most effective form of treatment is *prophylaxis*. In the routine examinations of all our patients from fifty on this matter should be constantly kept in mind. Obesity should be controlled; the kind and amount of exercise should be discussed; details of the patient's work should be ferreted out; and the intricacies of housework should be discussed with the housewife. By attention to all of these details much can be accomplished in the prevention of hypertrophic arthritis.

REGIONAL INJECTION OF THIAMIN CHLORIDE IN HERPES ZOSTER

By SYDNEY F. SMITH, M.D., Highland Park, N. J.

The treatment of herpes zoster is often unsatisfactory and many forms of therapy have been advocated. Piotrowski³ described the use of extract of posterior pituitary with only fair results. Several of his patients had relapses. Walker⁴ gave a subcutaneous injection of 5000 units of diphtheria antitoxin in a case of herpes zoster of the eye and forehead, with relief in 24 hours. Keichline⁵ treated 62 cases of herpes zoster with x-ray over the area of eruption and the corresponding ganglia, using 148 r through a 3 mm. aluminum filter at a distance of 30 cm. Ninety per cent of the cases were relieved by one dose; the others required one or two additional exposures. Ruggles² has used intravenous injection of sodium iodide, while Rosenak⁷ employed procaine injected into the region of the spinal ganglia involved. In the cases to be described, injections of thiamin chloride into and beneath the skin of the area of zoster brought about gratifying relief.

CASE 1

The patient, a man of 51, complained of severe burning pain in the left lower trunk area for a day and a half. Pain was incessant, agonizing and incapacitating. He had marked insomnia, malaise and anorexia.

He was a well-developed and ordinarily phlegmatic male. Heart, lungs and abdomen were normal. Blood pressure was 110/74.

Three large erythematous patches were present in the skin of the lower trunk along the course of the cutaneous branches of the left iliohypogastric nerve. One patch was dorsal, approximately 3" x 4", deep-red in color, covered with small, pin-head, tense, glistening, globular vesicles. Another patch was about 2½ inches anterior to this, and about 2½" x 2" in size. A third patch was situated anteriorly in the suprapubic area, about 2" x 3" in size and ended exactly in the mid-line. All the patches were so hypersensitive to touch that the patient

had covered his entire lower trunk with rolls of cheesecloth to prevent contact with his clothing.

A diagnosis of herpes zoster was made. Flexible collodion was applied locally, and 10 mg. (1 c.c.) of thiamin chloride (Squibb) were given intramuscularly into the deltoid region. The patient had no relief, and on the second day the dosage was repeated. On the third day the patient was in great distress and almost hysterical because of pain and lack of sleep. Redness was still marked in the affected areas and additional vesicles had appeared. At this time it occurred to me that treatment with thiamin chloride might be made more effective if the material were injected directly into the dermatome involved. The collodion was removed from the inflamed areas, and 1 c.c. (10 mg.) of this thiamin chloride was injected intracutaneously and subcutaneously into a clear area of skin between the anterior and lateral patches of eruption.

Two hours later the patient telephoned enthusiastically that his pain had practically disappeared, and that he was going out for a drive and for his first good meal in days. Next day the erythema had diminished markedly and no new vesicles had appeared. Two more injections were given in the same manner on successive days; after this, the erythema and pain entirely disappeared. The vesicles had now become completely dried and covered with small crusts and the patient returned to work. Since then he has been completely symptom-free.

CASE 2

Another patient, a man of 57, had similar complaints, but with a distribution of the herpetic vesicles about the left side of the upper chest, upper left arm, shoulder and back. Symptoms were severe. Thiamin chloride was injected intracutaneously and intradermally, 1 c.c. to the anterior lesions, 0.5 c.c. to the shoulder and 1 c.c. to the back. The patient was seen again about 20 hours later, at which time the redness of the lesions had markedly diminished. The technique was repeated on each of the following three days, by which time the pain was minimal, redness had disappeared and the vesicles had completely dried.

CASE 3

My third patient, a man of 61, complained of burning and discomfort along the course of the cutaneous branches of the right iliohypogastric nerve for three days. Symptoms became severe with the appearance of vesicles and redness in patches. On this day, two cubic centimeters of thiamin chloride were injected intradermally and subcutaneously about the herpetic patches. No sedation or other medication was used. Within six hours, according to the patient, the burning and irritation had much diminished. The procedure was repeated on each of the following two days, by which time all red-

1. Steinberg: Untoward Effects Resulting from Use of Large Doses of Vitamin B-1. *Am. J. Digestive Diseases*, Dec., 1938, 5:680.

2. Ruggles: Effect of Sodium Iodide in Herpes Zoster. *Archives Derm. & Syph.*, 1931, 23:472.

3. Piotrowski: Treatment of Herpes Zoster by Extracts of Posterior Lobe of the Hypophysis. *Paris Medical*, 1:482, May 29, 1937.

4. Walker, J. R.: A Specific Treatment of Herpes Zoster. *Archives of Ophthalmology*, 20:302, August, 1938.

5. Keichline, John M.: Sixty-two Cases of Herpes Zoster Successfully Treated with X-Ray. *Radiology*, 22:372 (March) 1934.

ness had disappeared and the vesicles had completely dried, except for one which had apparently been ruptured by trauma and had formed an ulcer. The ulcer was treated symptomatically with alcohol and azachloramide dressings and was completely healed in four days.

These patients were seen later and all have remained symptom-free.

COMMENT

The literature is replete with the benefits of thiamin chloride in many diseases of the nervous system. It may be, as Wechsler¹² says, that avitaminosis is an important factor in these cases. In respect to herpes zoster, however, a different mechanism probably exists. Steinberg,¹ for example, noted three cases of herpes zoster occurring in the course of treatment of 390 cases of chronic arthritis with vitamin B₁. He attributed this complication to massive overdosage with thiamin chloride. This has not been confirmed by others. Vorhaus¹⁴ used thiamin chloride successfully in peripheral neuritis of unspecified type. Stevenson¹¹ used it intramuscularly in sciatica and in general nerve pain and reported success in 63 per cent of cases. Rattner and Roll⁶ used thiamin chloride subcutaneously in doses of 2000 units every two or three days in herpes zoster. Indifferent results were obtained, but this was attributed to the advanced age of the patients and the tardiness of treatment. Nitzulescu and Triandaf¹³ used thiamin chloride with excellent results in herpes of the cornea.

The technic of injection directly into the diseased dermatome, here suggested, has not apparently been employed hitherto. In the cases presented, thiamin chloride was given into only a small area of the region affected. It is unlikely therefore that a purely local effect on nerve endings can explain the remarkable improvement. Absorption along lymphatics may bring about a high concentration of thiamin chloride in the region of the affected dorsal ganglia. Perhaps the effect is nonspecific, and

other substances, e. g., choline derivatives of histamine, may achieve the result.

Reference should be made to the observations of Rosenak,⁷ who injected 0.5 per cent procaine into the intervertebral ganglion and prevertebral sympathetic cord of the area of skin affected by zoster, using 8 cubic centimeters to each segment. In trigeminal zoster, he injected the Gasserian ganglion. Rosenak⁷ reported cures within 48 hours. On the other hand, Ming⁹ and Abderhalden¹⁰ have shown that thiamin chloride augments the physiologic action of acetylcholine. Glick and Antopol⁸ corroborate this and suggest that this effect is achieved through the action of thiamin chloride in inhibiting choline esterase, thereby heightening the effect of acetylcholine. They demonstrated that the affinity of thiamin chloride for choline esterase was twenty-six times that of acetylcholine itself. It is theoretically possible then that the effect here was mediated through changes in the physiology of nervous conduction. For the present, further speculation is better withheld until corroboration and evaluation of this result are obtained in other cases.

SUMMARY

Rapid amelioration of symptoms was brought about in patients suffering from painful herpes zoster of the trunk by injection of thiamin chloride directly into the involved segment of the skin. The theoretical implications of this result are briefly discussed.

6. Rattner, Herbert and Roll, Harvey C.: Herpes Zoster and Vit. B₁. *J. A. M. A.*, 112:2585, June 24, 1939.

7. Rosenak: Procaine Hydrochloride in Herpes Zoster. *Lancet*, Nov. 5, 1938, 2:1056.

8. Glick and Antopol: Inhibition of Choline Esterase by Thiamin Chloride. *J. Pharm. and Exp. Therap.*, April, 1939, 65:389.

9. Ming, B.: Role of Vitamin B₁ in Humoral Regulation of Nervous System. *Presse Medicale*, Nov. 21, 1938, 46:1406.

10. Abderhalden, E.: *Klin. Wochenschr.* 17:1195 (1938).

11. Stevenson, D.: *The Practitioner*, 140:301 (1938).

12. Wechsler, I. S.: *Archiv. Neurol. & Psychiat.* 29:813 (April, 1933).

13. Nitzulescu, J., and Triandaf: *Brit. Journ. of Ophthalmology*, 21:654 (1937).

14. Vorhaus, M. G.: *Amer. Journ. Dig. Diseases and Nutrition*, 3:915 (Feb., 1937).

THE DRAFT BOARD PHYSICIAN'S RESPONSIBILITY IN NATIONAL DEFENSE

By THEODORE ROBIE, M.D., Montclair, N. J.
Secretary, New Jersey Neuro-Psychiatric Association

It cost the taxpayers of this country \$30,000 for each man inducted during the World War who later developed a mental breakdown. Added to this was the incalculable damage done by the 100,000 neuropsychiatric problems accepted in the 1917 Army. In modern mechanized war, an unstable man may lose a battle or a battleship. The damage that may be done by an acute hysterical outbreak by one man on the eve of a crucial battle is inestimable. A smouldering incipient psychosis breaking out in a military company can do more harm than hundreds of bullets.

It is therefore to the interest of every citizen (and important to the prestige of the medical profession, too) that draft board doctors eliminate those who show psychologic inaptitude for army service. The time to take this step is before, not after induction. While a practicing physician can not become a trained psychiatrist overnight, it is expected that local draft board doctors will make every effort to fit themselves quickly for the job of selecting for the army the cream of the American crop. Reports concerning psychiatric casualties in the present war from English and Canadian sources already available show that in many of those found to be mentally sick after induction the disorder was obvious at the time of induction. This means that the physician's examination was inadequate, for otherwise the subject would have been rejected.

It is most unfortunate when those in high places become deluded with the belief that army life will "make a man" out of one who carries the constitutional germs of a mental breakdown. One of our generals recently asserted that it is the government's responsibility to induct the unfit in our army and salvage them. It is a short-sighted philosophy which asserts that the army can "rehabilitate physically and mentally the increasing number of

individuals who have been rejected for mental deficiencies". The 1917-1918 war has taught us that the man with a mental disorder is a serious liability, rather than an asset, in the armed forces. Our mistakes in inducting so many psychiatric cases during the first World War have recently and properly been dubbed "the billion-dollar blunder".

Brussel,¹ psychiatrist at Fort Dix, shows that the same blunders are made today through seepage of psychiatric disorders into our draft army. He is finding "instances of post-traumatic psychoses and alcoholic disorders, especially paranoid and pathologic intoxication states. Epilepsy and mental deficiency with or without psychoses should not appear, but occasionally do. Every epileptic admitted to this psychiatric service has insisted that he had never been questioned by the original examining physician as to history of convulsions. The same was true of a number of mental defectives whose appearance alone should have suggested deficient intelligence." The taxpayers must pay for these errors of omission on the part of our examining physicians, once the selectee is inducted.

Many epileptics could be sifted out by the simple expedient suggested by one of the psychiatrists at the Newark Induction Center, who asks each draftee: "How often do you have fits?" This will often bring out the truth where another approach would fail to do so.

In our own State the psychiatrists are alert to this problem. Statistics made available in May, 1941, showed that 20 per cent of those passed by draft board examiners were rejected by the psychiatrists at the induction stations. The saving in dollars which this means to the taxpayers is enormous. But there would be less embarrassment to the registrant and to the doctors if these potential psychiatric casualties could be screened out by the draft board physician.

1. Brussel, James A.: *Mil. Surg.*, May, 1941, p. 539.

MENTAL DEFECTIVES

First, the draft board physician should weigh carefully Myerson's² concepts. He says:

"Most of the feeble-minded should be excluded, especially in a war which has gone beyond the stage of hand-to-hand conflict, and where the handling and control of machinery becomes the prime asset of the soldier." (The largest single grouping of psychiatric casualties in our World War army was the feeble-minded. The time necessary to carry out an intelligence test in any doubtful case will prove well spent, especially when the army is saved the expense and handicap of the erroneous induction of a mental defective.)

SOCIAL NEUROSES

"I place in the first rank of the personalities unfit for army service those I label *social neuroses*. Abnormal shyness, manifested by an increased and disagreeable reactivity to the society of others, is the rule with these sufferers. When a man repeatedly and continuously in the presence of others becomes shaky, has heart-pounding, suffers disagreeable activities of his gastro-intestinal and genito-urinary tracts, so that he has a feeling of nausea or a sense of urgency, he is, on the whole, a bad risk for the army."

PARANOID PERSONALITIES

"A second group of equal importance includes those who continually feel they have been slighted, snubbed or unfairly treated. They have a paranoid attitude, that is, an attitude of suspicion and hostility by which every non-relevant remark is construed as injuriously directed toward themselves. Such a person usually has a history of frequent changes of jobs, of recurrent quarrels and sudden outbursts of anger. He has few, if any, friends and tends to become more solitary as time goes on.

UNSTABLE PERSONALITIES

"A third type includes those individuals with unstable mood. The manic-depressive state manifests itself by cycles of depression or exhilaration that reach levels which disorganize

the individual for activity of any type. A history of periods of gloominess with insomnia and anorexia, or periods of unaccountable exhilaration, talkativeness and facetiousness with marked insomnia, suggests this personality deviation. Unless the person has particularly great assets of personality and character, he does not constitute a good risk for the army. The question can be decided only by a detailed study by a psychiatrist before induction.

SCHIZOID INDIVIDUALS

"The fourth type is the schizoid individual. Here the individual is over-deliberate, unable to adapt, and considered an 'odd stick'. It is likely that such a personality will be inadequate in capacity or ability, and will consequently act as a sort of splitting factor in the group, just as he is himself a split personality. The individuals may become the butt of others in their group and thus create disturbances of discipline unwittingly and involuntarily. In general a personality of this type, being overly suspicious and excessively sensitive, is not a good risk for the army. It is far better for the draft board physician to reject him in advance than to permit his induction with the probability of a schizophrenic breakdown after induction, followed by the necessity of prolonged or permanent hospitalization—a very costly item for the taxpayers, indeed.

HOMOSEXUALS

"Another type which the examining physician should watch for is the feministic individual. In most men, dominant maleness is the rule, but there are many intermediate grades of expression, ranging from the very aggressive masculine type all the way to the very passive feminine type of male. These latter may be fundamentally masculine in sexual drives but are feministic in appearance, taste, and even in actions. Such individuals arouse derision, which militates against success in army life. The feministic individual is not necessarily cowardly and may make a good soldier; but his adaptation to life in the army would prove most difficult.

2. Myerson, Abraham: Talk to American Psychiatric Association, Richmond, May 15, 1941.

However, the physician should be careful not to confuse refinement and gentleness with effeminacy, for the former attributes are entirely compatible with masculinity.

PSYCHOPATHIC CONSTITUTIONS

"The last group to be considered are by far the most difficult to detect during initial examination. (In a study of 200 consecutive neuropsychiatric ineffectives in the present Canadian Army, the largest percentile group [35 per cent] fell in this category. Many psychopaths have been collecting compensation in the United States since the last war, having served but a short time before discharge for psychiatric disability.)

"The psychiatrist has given a name to the group: *psychopathic personality*, or as the fashion shifts, *constitutional psychopathic inferiority*. Generally speaking, these people are usually of fair intelligence; they may have superior capacity, but they cannot discipline their personalities to social requirements. They are incorrigible, sometimes fantastic liars. This pathologic lying becomes conspicuous if one has their history, but since they present a good appearance and they are not physically defective, they may pass draft and induction boards and appear in the army. The thing to do is to get rid of them as fast as possible once their character has been established by the career within the army."

"Constitutional psychopaths seem unable to profit by experience, to respond in an adult social manner to the demands of honesty, truthfulness, decency and consideration of their associates. They act impulsively and with poor judgment. They are always in difficulties, have many and various schemes without any logical basis, lack tenacity of purpose, and are often in conflict with the law. They do not

take kindly to regimentation and will not conform to organized authority. They cultivate insubordination in others, and are thus sometimes dubbed 'guardhouse lawyers'."

ORGANIC NEUROLOGIC DISORDERS

Many organic neurological disorders are discovered by adequate physical examination. Multiple sclerosis, progressive muscular atrophy and dystrophy, syringomyelia, syphilitic spinal disease, or other frank neurologic disabling disorders are, of course, bases of rejection. Draft-board physicians are urged to read the Surgeon General's Circular Letter³ No. 19 and to review Campbell's recent article⁴ on Selective Service. The New Jersey Neuro-Psychiatric Association⁵ will be glad to advise with any draft board physicians who have difficulty in securing the aid of a psychiatrist for studying registrants who present difficulty in personality diagnosis.

CONCLUSIONS

1. The physicians on every local draft board have a unique opportunity to serve the country in selecting our best fighting men for the armed forces.

2. At the same time these physicians have the grave responsibility of sifting out for deferment or rejection every draftee likely to become a psychiatric casualty following induction.

3. This problem is an acute one and no words can emphasize the fact better than General Pershing's cable from France in July, 1918: "Prevalence of mental disorders in replacement groups recently received suggests urgent importance of intensive efforts in eliminating mentally unfit from organizations of new draft prior to departure from the United States."

4. Points to observe which may prove helpful to the physician in detecting frank or incipient neuropsychiatric disorders have been outlined.

3. Journal Am. Med. Assn., May 13, 1941, p. 2509.

4. Campbell, C. M.: Journal Am. Med. Assn., April 26, 1941, p. 1883.

5. Communications may be addressed to the Secretary of the Association, Dr. Theodore Robie, 144 Harrison Street, East Orange.

TREATMENT OF BLOOD DYSCRASIAS IN INFANCY AND CHILDHOOD

By WALTER B. STEWART, M.D., Atlantic City, N. J.

Read before the Pediatric and Radiology Section of the Annual Meeting of The Medical Society of New Jersey, June 4, 1940.

Recent research on vitamin K has completely transformed hemorrhagic disease of the newborn from an almost hopeless condition to one of relatively little danger. Thus one of the most important of the blood dyscrasias of infancy seems on the verge of solution. The two richest sources of vitamin K in nature are alfalfa and decayed fish, although many articles in the average diet contain smaller amounts of this substance. It is now known that vitamin K is absorbed in the intestinal tract only when bile is present, and is carried by the portal vein to the liver, where it is utilized in the synthesis of prothrombin. In obstructions of the biliary tract, with failure of bile to enter the small intestine, vitamin K is not absorbed, the plasma prothrombin drops to a low level, and bleeding occurs readily.

The normal limits of prothrombin concentration in the blood are considered to be from 70 to 100 per cent. A concentration of 50 to 75 per cent requires investigation, since any appreciable amount of hemorrhage will occasion a further loss of prothrombin. From 20 to 50 per cent of normal the decline is dangerous because of post-operative bleeding. At 20 per cent the least trauma will initiate bleeding, and 10 per cent is the critical level at which spontaneous bleeding will occur.

This is a much more sensitive index of danger than the ordinary coagulation time of Rodda, which may not become prolonged above normal limits until the prothrombin level has fallen far down the scale. Coagulation time, however, sensitized by the addition of an excess of thromboplastin and calcium, according to the method of Quick, is a rough quantitative measure of the prothrombin content. The longer the prothrombin clotting time of Quick, the smaller the amount of prothrombin present. This prothrombin test does not replace the coagulation test of Rodda; it is merely a refinement of the latter as a diagnostic procedure.

The prothrombin clotting time of the newborn infant is about twice that of the normal adult—43 seconds, as compared with 20 seconds in the adult. During the first three or four days of life, infants show great individual variations in prothrombin content from day to day and even from hour to hour. At birth the concentration of prothrombin is nearly normal; but after the tenth hour there is often a sudden decrease. Apparently prothrombin is consumed in forming a clot in the umbilical stump and perhaps elsewhere. The prothrombin thus lost is not replaced, because the infant lacks vitamin K. The subsequent sudden, spontaneous rise in prothrombin is caused by the entrance into the intestinal tract of bacteria which produce additional vitamin K by synthesis, as shown first by Dam and Schonheyder. It is this sudden fall in prothrombin during the first few days of life which may produce bleeding in the newborn. Hence, hemorrhagic disease of the newborn must be classed among the *vitamin deficiency* diseases and treated as such. The probable underlying cause of this deficiency in vitamin K must be sought and found in the maternal diet.

Vitamin K is available in several forms today, one of which, Klotogen, is a petroleum ether extract of alfalfa. Each capsule contains 1000 units of the vitamin, and each cubic centimeter of the oily solution contains 1250 units. It has been used with great success not only in the treatment of hemorrhagic disease but also in its prevention. A prophylactic dose of 0.5 c.c. every six hours may be given to the newborn infant during the first three days. It is given orally together with bile salts, such as sodium deoxycholate (0.015 to 0.4 gm. daily) or the Iron Bile Salts of Lilly (0.6 to 2.0 gm. daily). The therapeutic dose of vitamin suggested by Quick is one dram every six hours until the prothrombin level has reached normal.

The most recent development in this field

has been the isolation of synthetic 2-methyl-1, 4 naphthoquinone, which possesses marked vitamin K activity. This substance is being administered orally in small amounts for prothrombin deficiency in several clinics. At the Johns Hopkins Hospital it is being given routinely to all expectant mothers upon admission in a dosage of one mg., in order to prevent the development of postpartum hemorrhages in the newborn. The immediate result is a rise of the prothrombin level to normal within a few hours of administration of the drug. Maternal prothrombin usually is normal; but in the relatively small number who show a lowered level, this is promptly raised to normal by the vitamin. The results of *treatment* of hemorrhagic disease of the newborn with vitamin K, however, have been highly successful in almost every instance.

Two cases of this disease recently appeared in the obstetrical nursery of the Atlantic City Hospital within a few days of each other.

CASE I

An eight-and-a-quarter-pound colored infant, normal at birth, began to ooze at the umbilicus after 48 hours. Mechanical control of the bleeding was ineffectual. The hemoglobin fell to 6.5 gm. per cent. Treatment consisted of 20 c.c. of maternal blood intramuscularly, and one capsule of Klotogen by mouth every six hours for the first day. Bleeding ceased after twelve hours. Convalescence was rapid and uneventful.

CASE II

A seven-and-a-quarter-pound white infant, normal at birth, began to bleed from the nose and mouth twenty-four hours after delivery. Twelve hours later bright blood was noticed in the stools, followed soon by the vomiting of large amounts of blood. In one day the hemoglobin fell from 15.5 to 11.5 gm. per cent. Treatment consisted of one capsule of Klotogen every six hours during the first twenty-four hours, and 20 c.c. of whole maternal blood intramuscularly. No bleeding, except for tarry stools, occurred after that. Convalescence was normal and rapid.

There are several indications for the therapeutic administration of vitamin K: (1) The appearance of any bleeding in the newborn infant. (2) Any emergency operation on a baby less than ten days old. (3) A difficult delivery with concomitant danger of intracranial hemorrhage. In certain cases of this last-named condition occurring at birth, it is

very likely that trauma or difficult labor may play only a provocative rôle, the fundamental factor being a reduced prothrombin convertibility of the blood, a condition which naturally renders the patient susceptible to severe bleeding on the slightest provocation. Twenty-five to forty per cent of all fetal deaths encountered in this country are caused by intracranial hemorrhage of the newborn. If such a tragic condition can be prevented or minimized by thus controlling the plasma prothrombin, one of the greatest triumphs of vitamin K therapy will have resulted.

NUTRITIONAL ANEMIA OF CHILDHOOD

In contrast with the rare hemorrhagic disease, one may place the exceedingly common nutritional anemia of childhood. It should be seen at once that in this, as in other abnormalities of the blood, prothrombin determinations will play an increasingly important rôle in the detection of latent bleeding tendencies, and vitamin K will loom larger in the therapeutic attack.

Nutritional anemia occurs with considerable frequency even during these days of nutritional enlightenment. The most common age period is from six to eighteen months, after the initial supply of iron in the neonatal liver has been exhausted and has not been replaced by dietary iron. The chief offender is the lazy mother who has continued to nurse the baby without giving any other food during the latter part of the first year; or who has given nothing but bottle milk during a time when the child should be receiving green vegetables, eggs, and meat.

The vitamins naturally have been thought of in connection with the dietary anemias, such as the long-suspected connection between rickets and the von Jaksch syndrome. It is not generally believed that there is a demonstrable connection between any of the avitaminoses and a definite type of anemia. It can be stated that when avitaminosis and anemia are coincident, the anemia may be cured by the measures taken for the deficiency disease, without definite anti-anemic therapy.

In these cases prothrombin determinations should be made, and if it is found below normal, vitamin K should be given. Saccharated

ferrous carbonate in large doses, 20 grains three times a day, has been found most effective in combating the secondary anemia.

CASE III

In one case of this type the hemoglobin was increased from two gm. to thirteen gm. per cent during the course of one month. This child had received nothing by mouth except his mixture of cow's milk, water, and sugar during the first year of life, up to the time of admission to the hospital. In addition to the waxy white color of skin and mucous membranes, he had a flabby, malnourished body, with some signs of rickets and a moderately enlarged spleen.

Treatment consisted solely of a well-balanced diet, with especial emphasis on green vegetables, egg yolk, and meat, and large oral doses of saccharated ferrous carbonate. Response to this alone was unexpectedly rapid. Nutrition was much improved, and the general appearance readily corroborated the rise in hemoglobin of eleven gm. per cent in the space of one month. This, however, was an extreme example of milk anemia, such as is seldom seen today. The baby is now an adolescent boy, healthy in every respect, except for a body height about five inches under the normal for his age.

CASE IV

Another case of nutritional anemia was treated recently in the Atlantic City Hospital, an infant aged one year, one of twins, the other being normal. Birth weight was four and one-half pounds, and weight at one year was twelve and one-half pounds. Feeding had consisted almost entirely of evaporated milk formulas plus occasional cod-liver oil, but no orange juice and no other foods.

In addition to the pronounced anemia of 2,500,000 red blood cells and four gm. per cent of hemoglobin, with a 16,000 white-cell count and a 64 per cent preponderance of small lymphocytes, there was a huge, firm spleen filling the left side of the abdomen down to the crest of the ilium, and a liver reaching to the level of the umbilicus.

A few lymphoblasts and premyelocytes were present among the white blood cells. The blood Wassermann and Kline tests were negative; and the icterus index was normal. The fragility test showed red cells of normal resistance.

Treatment consisted of a diet rich in iron, taken only with much persuasion at first, large amounts of saccharated ferrous carbonate, and two c.c. injections of concentrated liver extract every other day.

One transfusion of 150 c.c. of citrated blood was given on the day after admission. There was a prompt improvement in the condition of the child, so that at the end of five weeks in the hospital, the red-cell count had risen to 4,400,000, the hemoglobin to 10.5 mg. per cent, the abnormal cells had disappeared, the spleen had shrunk to half its previous size, and the liver appeared normal.

Since there was considerable cellular regeneration in the blood and a moderate amount of rickets clinically, the case may be classified as a nutritional anemia of a type often spoken of as the von Jaksch syndrome—rickets associated with secondary anemia of the actively regenerating type, a moderate leukokytosis, and a large spleen.

In addition to hemorrhagic disease of the newborn and nutritional anemia, a few other blood dyscrasias of children usually respond well to therapeutic measures. Among these are the anemias secondary to infection, hemolytic icterus, and many of the purpuras.

The larger group includes those cases which respond only temporarily or not at all to our present methods of treatment. Among these are the leukemias, erythroblastic anemia, sickle-cell anemia, and aplastic anemia, all of which, however, are relatively rare conditions.

From this discussion it is apparent with what rapid strides the treatment of blood dyscrasias is advancing, but it is even more apparent how much real work remains to be done.

TO THE DOCTOR

"There are men and classes of men that stand above the common herd; the soldier, the sailor, and the shepherd not infrequently; the artist rarely; rarelier still, the clergyman; the physician almost as a rule. He is the flower (such as it is) of our civilization; and when that stage of man is done with, and only remembered to be marveled at in history, he will be thought to have shared as little as any in the defects of the period, and most notably exhib-

ited the virtues of the race. Generosity he has, such as is possible to those who practice an art, never to those who drive a trade; discretion, tested by a hundred secrets; tact, tried in a thousand embarrassments; and what are more important, Heraclean cheerfulness and courage. So it is that he brings air and cheer into the sick room, and often enough, though not so often as he wishes, brings healing."—Robert Louis Stevenson.

THE SURGICAL TREATMENT OF THE COMPLICATIONS OF PEPTIC ULCER

By GEORGE P. MULLER, M.D., Philadelphia, Pa.

Read before the Combined Sections on Medicine and Gastro-enterology of The Medical Society of New Jersey at Atlantic City, June 4, 1940.

The surgical treatment of peptic ulcer properly may be stated as the surgical treatment of the *complications* of peptic ulcer. The improvement in the care, the diet and the treatment of ulcer seems to result in the cure of a large proportion, possibly 80 per cent, of peptic ulcer by medical means.

A certain percentage of ulcer, for various reasons, resist treatment by rest, diet, and medication; and failure to heal results in chronic, deep, penetrating ulcers. The patient suffers from pain, unrelieved except by the most rigid treatment from which in time he rebels.

On the duodenal side such ulcers as are on the anterior wall may perforate; and of course this constitutes an urgent and immediate indication for surgical treatment. On the posterior wall these ulcers may erode the artery, and give rise to severe or massive hemorrhage. The immediate hemorrhage may be relieved by medical treatment; but in my opinion it almost invariably recurs, and hence I believe that severe bleeding with a penetrating posterior wall ulcer is an indication for operation.

On the gastric side such ulcers may perforate less frequently, hemorrhage less frequently, but in those over fifty years of age the diagnosis from carcinoma is made with difficulty in the stage when cure may be expected of a cancer; and hence I believe that all penetrating ulcers of the stomach itself should be operated upon unless it can be demonstrated that they will heal after not more than two months of medical treatment; and this demonstration must be made by x-ray examination, possibly by gastroscopy, and not by relief of symptoms.

A certain proportion of ulcers in the pyloric area, whether duodenal or stomach in origin, produce stenosis while healing. This results in obstruction and the retention of stomach contents. It cannot be relieved except by surgery

although some cases of supposed stenosis may be due to edema which subsides under rest and diet and may enable the patient to escape operation.

We believe that there are three examinations of importance, namely, that of the gastric acidity, the behavior and appearance of the stomach and duodenum under the fluoroscope, and the picture seen by the use of the gastroscope in the case of gastric ulcer.

The estimation of the acid in the gastric contents is important because gastroenterostomy is rarely done except in those cases of stenosis with low free hydrochloric acid, and for elderly patients with penetrating ulcers with no obstruction, and low acid. With high acid content gastroenterostomy may give relief of symptoms in most cases, but fails to permanently lower the acid; and hence there are too many cases of recurring ulcer or of marginal ulcer at the point of juncture.

Perforation demands immediate operation and the mortality will be low if the opening is closed within twelve hours of perforation. With any reasonable history indicating ulcer and with the sudden onset of extreme pain and board-like rigidity the examination should be made and operation performed at once. It is unnecessary to waste time with x-ray examinations hunting for air under the diaphragm. Today, suture and patching with omentum is the method of choice, gastroenterostomy rarely being necessary. A small percentage will require a secondary operation for recurrence of symptoms, usually those of obstruction.

Hemorrhage is considered as an indication for operative treatment. By this is meant not the seepage of blood detected as occult blood in the feces, but the hemorrhage which is severe enough to give clinical symptoms of the shock-phenomena and manifest by tarry stools or hematemesis.

The patient is treated for the hemorrhage by complete rest, by a low fluid intake, and the administration of the Meulengracht or Andresen diet. In cases of average moderate bleeding we do not give blood transfusion for several days, but if the hemoglobin is under forty and the red cells under two million it is better to begin daily blood transfusions. If they are administered quite slowly there is but little risk of raising the blood pressure. I have had no experience with the continuous administration of aluminum hydroxide. We would also use vitamin C, iron, liver, but by this time the patient is put under the care of our medical colleague.

Most cases of hemorrhage from ulcer recover under medical treatment; and when the hemorrhage is over, the patient should be subjected to careful x-ray examinations to determine the nature of the lesion. If he has a deep, penetrating ulcer he will almost certainly have a recurrence of the hemorrhage; and it seems to me best to subject these patients to operation when their condition permits. This is particularly so in those over fifty years of age because of the more rigid nature of the blood vessels. Sometimes it is necessary to operate during the hemorrhage because of the fact that it does not cease, and the patient's condition keeps getting worse. In such cases we would advise that continuous intravenous infusion of blood should be begun, and kept going on through the operation and afterwards. We would try to replace the blood as fast as it is lost from the bleeding artery.

Practically all of these cases occur from the posterior duodenal wall ulcer, and the surgeon must open the duodenum and by mattress sutures endeavor to control the bleeding. Control of the hemorrhage might be assisted, if the condition warranted, by exposing the trunk vessels at the pylorus and at the inferior edge of the pancreas posteriorly with ligation. In such patients, again if the condition permits, gastroenterostomy also should be done and

later if the gastric acidity remains high, a resection should be performed.

In those cases in which the hemorrhage has been controlled by medical means and the penetrating ulcer diagnosed, the subsequent operation should consist of a subtotal gastrectomy.

Each patient must be treated as an individual because in addition to the pure mechanics of the situation there is a constitutional state and tissue susceptibility and then again there is the matter of the state of mind of the patient. Some patients will not go on diet, others will not cease smoking. Generally speaking, I believe that in the chronic ulcer with complications, particularly penetration or obstruction, gastroenterostomy is rarely indicated and only in cases of stenosis with a low gastric acidity or in elderly persons with penetrating duodenal ulcers without hemorrhage and also low acidity. In all other cases, subtotal gastrectomy should be the operation of choice and we prefer either the posterior Polya or the anterior Hofmeister method.

In view of the well-known wretched end-results of carcinoma of the stomach I believe that we should always lean to the side of radical surgery in cases of chronic stomach ulcer. Certainly no medical treatment can cure the cancer and if diagnosis is delayed unduly in the attempts to so cure the lesion the patient passes into the stage of incurability.

As a result of the changing point of view regarding ulcer, the surgeon is confronted with the necessity of knowing how properly to prepare these patients for operation and how properly to do the operation. One should not attempt operations for ulcer unless prepared to do a subtotal gastrectomy under the indications. The history of the patient with the relative frequency of jejunal ulcer is the reason for this statement. This condition, namely, jejunal ulcer, is a dreadful lesion, most difficult to treat, and requiring release of the gastroenterostomy and the doing of a subtotal gastrectomy.

THE DIAGNOSIS OF ANNULAR LESIONS OF THE SKIN

By C. C. CARPENTER, M.D., Summit, N. J.

Read at a meeting of the Summit Medical Group on January 21, 1941.

It is a dangerous practice to make a diagnosis of ringworm of the skin by casual inspection of an annular lesion. In reviewing a series of 3,750 skin diagnoses, it was found that approximately 14 per cent of them showed annular lesions at some time during their course. Many of these circinate configurations showed characteristics distinctive enough in themselves to permit of a diagnosis, but for the most part the clinching evidence came from a careful inspection of the whole skin, scalp, nails, and mucous membranes, in search of skin manifestations that had been overlooked by the patient as being wholly unimportant.

For purposes of study, the charts of unselected, consecutive admissions for skin diseases were divided into those commonly and those rarely seen. Table I summarizes the findings of the frequency of annular lesions in these two groups.

eases showing circular configurations are the nodular ulcerative type of tertiary syphilis, the occasional annular syphilide found in the secondary stage in the colored race, lupus erythematosus, flaccid bullae of pemphigus, granuloma annulare, scleroderma, dermatitis vegetans, erythema annulare centrifugum, and purpura annularis telangectoides. They furnished the two per cent of annular lesions recorded in this group in Table I.

ECZEMA

The annular lesions of eczema are most frequently found on the flexor surfaces, and are usually more exaggerated near the popliteal and cubital fossae. For the most part their distribution is symmetrical and, during some stage, they have a tendency to exude a clear serum which will stiffen linen. Itching as a rule is more intense than is found in the other

TABLE I

	Admissions	Annular Lesions Occurred
Common dermatoses selected for study	2,000	23%
Uncommon dermatoses	1,750	2%
Total	3,750	Average 14%

In the group of common dermatoses it was of interest to note the frequency with which annular lesions appeared among those patients suffering from the same type of skin disease. This is recorded in column A of Table II. Thus, it may be seen that pityriasis rosea had an annular configuration sometime during its course in 75 per cent of the cases, whereas in toxic erythema these formations were only encountered in one case in ten. Column B of Table II gives the frequency ratio of circinate lesions among the commoner skin diseases. Thus, annular lesions produced by seborrhea will be encountered five times more frequently than those of lichen planus.

Among the uncommon forms of skin dis-

skin diseases having circinate arrangements. Although papules may be only at the active periphery of an orbicular or nummular eczema, they are for the most part found scattered through the clearing center as well. Other factors which should be considered in a diagnosis of eczema are a history of previous familial hay-fever, asthma or eczema, long-standing seborrhea, ichthyosis, metabolic disorders, particularly with regard to assimilation of carbohydrates, and recent tinea of the feet or hands.

IMPETIGO

The disease most commonly confused with ringworm of the face or body is *bullous impetigo*, with its few flaccid lesions. A con-

TABLE II

Diagnosis	"A" Annular Configuration Present	"B" Ratio of Frequency
Eczema	36%	20
Impetigo	26%	11
Pityriasis Rosea	75%	8
Tinea (axilla and groin)	15%	5
Seborrhea (body)	24%	5
Epithelioma	65%	5
Tinea Circinata	100%	3
Psoriasis	35%	2
Toxic Erythema	10%	2
Erythema Multiforme	45%	2
Lichen Planus	60%	1

tagious element is noticed in both and a history of contact with animals may usually be obtained. However, when the crusted portion is removed, the characteristic moist, red base, with an undermining of the peripheral horny layer is found. There is also a gyrate form of impetigo which has the characteristic pustular crusts with upturned margins and central healing. About a quarter of the cases of impetigo that have been reviewed in this series showed annular lesions of these types.

PITYRIASIS ROSEA

Pityriasis rosea is a fairly common disorder which is seen more frequently in the Spring and Fall. In our series, 75 per cent of the cases began with a "herald plaque" which consisted of an annular, scaly lesion, varying in size from a dime to a silver dollar, with pink to chamois-colored, uninvolved centers, located for the most part on the anterior chest wall¹ and with a tendency to be beneath the left clavicle.² Within a week there are usually many scattered macular to oval, scaly lesions, similar to the initial plaque appearing on the body. These have a tendency to become progressively larger and they increase in size faster and show more scales than the macular syphilide with which they are occasionally confused.

TINEA

Of the two types of tinea which form definite, circular lesions, by far the more common is that seen in the inframammary, axillary and inguinal regions where the circles and gyrate forms may achieve quite a large size. In our series, tinea circinata, or that form occurring

on the dry, glabrous skin, was recorded in only four per cent, or once in every two hundred admissions. Its infrequent occurrence is borne out by the figures of the New York Skin and Cancer Hospital where, in 1930, it was recorded only once in every eight hundred admissions.³

It is easily differentiated from the other annular skin lesions in that a few scales removed from the active periphery and examined microscopically in a potassium hydroxide preparation will invariably show the branching fungi which produce this disorder.

SEBORRHEA

Seborrhea is the fifth commonest found in the group of selected cases. The type limited to the scalp and face was four times more frequent than that seen on the body. Annular lesions are, however, seen only on the neck and body in this disorder and, like psoriasis, their circular arrangement is due to a tendency to heal in the center and extend at the periphery. The border is made up of small, red papules covered with whitish-yellowish, dry or fatty scales, and such lesions are found mostly in the areas which are rich in "oil-glands", such as the sternal and intrascapular areas, axilla and groin.

EPITHELIOMA

The tendency of cutaneous cancer to extend at the periphery and ulcerate in the center causes this lesion to present an annular appearance in at least 65 per cent. However, the pearly nodular border, with surrounding telangiectasis, and central ulceration, with history of progressive but slow enlargement, makes this condition among the easiest to diagnose.

PSORIASIS

Psoriasis is a chronic, inflammatory disease, characterized by dry, reddish, rounded or oval patches with a shiney "mica-like" scale that has a predilection for the extensor surfaces. Starting as a papule, it extends peripherally and, in

1. Weiss, R. S., et al.: Pityriasis Rosea. Arch. Dermat. & Syph., 15:304, 1927.

2. Szaboky, J.: Monarch f. Prokt. Dermat., 43:495, 1906.

3. Forty-eighth Annual Report, New York Skin and Cancer Hospital, 1930.

the course of time, undergoes central regressive changes which leave a clear center and thus form circinate or segmented patches. Should the scales be removed at the periphery, small "pin-point" bleeding will be found scattered through the shiny, erythematous base. In this series, about 35 per cent of the cases had annular lesions at some stage.

TOXIC ERYTHEMA

Toxic erythema is a hyperemic, congestive disorder of the skin resulting from transitory upsets in metabolism, and absorption of toxins from the intestinal tract or bacterial products from foci of infection. For the most part there is a deep subcuticular flush or pinkish confluent macules; but in about ten per cent of our records, an annular or reticulated configuration was noted. Usually slight branny scaling may be seen as the erythema disappears.

ERYTHEMA MULTIFORME

Erythema multiforme is of diverse etiology, is characterized by crimson-red macules, pap-

ules and nodules, and is distributed for the most part on the face and dorsal surfaces of the extremities and rarely upon the mucous membranes. It has a tendency to form rings, with depressed centers and concentric arrangements, which are called "iris" lesions. These may coalesce with other circular lesions to produce gyrate figures. This tendency was noted in 45 per cent of our patients who presented this disorder.

LICHEN PLANUS

Lichen planus is a relatively rare disorder which accounted for only one per cent of the annular lesions in the studied cases. It may show annular lesions at certain stages of its development; but for the most part it is characterized by pin-head sized, purplish, glistening papules found on the inner surface of the wrists, and whitish streaks on the mucous membrane of the cheeks. As a rule, itching is pronounced, and the course is remittent. The older lesions, as they disappear, leave a pigmentation of brownish or bluish black hue.

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TREATMENT OF COCCYDYNIA

An original line of treatment is described which has given absolute satisfaction in relieving obstinate cases of coccydynia where the x-ray shows no evidence of bony pathology in the coccyx:

The patient is placed on the left side in Simm's position. The outline of the coccyx is noted by palpation and the area thoroughly painted with tincture of iodine. A total of 10 c.c. of 2 per cent solution of novocaine is then injected into the tissue directly adjacent to and on both sides and around the tip of the coccyx. This solution is allowed to remain for ten min-

utes at which time the tissue is absolutely non-sensitive. Then using a 10 c.c. syringe and following the original technique 10 c.c. of a hypertonic solution is injected in the same manner and in the same places that the novocaine solution was injected. The relief from the pain is immediate and usually lasts for a period of five to ten days. As soon as and if the pain makes its reappearance, the same procedure is repeated. Usually five or six of these injections at weekly periods is sufficient to permanently clear up the average case of coccydynia.—G. S. King, *Industrial Med.*, 1941 (Clinical Abstracts).

ONE HUNDRED FOURTEEN INTRANASAL ETHMO-SPHENOID OPERATIONS

By WILLIAM W. BURRITT, M.D., Summit, N. J.

Read on June 6, 1940, before the Section on the Eye, Ear, Nose, and Throat of the Annual Meeting of The Medical Society of New Jersey in Atlantic City, N. J.

This paper is not going to concern itself with the relative merits of various procedures. It will not delineate any program of diagnosis; and will be limited strictly to an analysis of the general outcome of 114 cases upon whom we have performed either unilateral, or bilateral, intranasal ethmo-sphenoid operations. All but four of these operations have been done under local anesthesia, using cocaine mud in the office.

There are always certain impressions one gains from practice in a field such as this. One of my strong impressions was that a great many cases of this disease were not being cleared up in childhood. And from the figures in the age-groups, this would seem to be borne out. There seem to be many of the adults who have had their disease since childhood, and here we have about the same number of children and adolescents affected as adults. I am sorry now that I haven't the figures for the number of years of the histories of the adults.

Another strong impression that I had was that a chronic infection in this region took years to cause polypoid degeneration. This impression does not seem to be borne out by the chart; for both of the four-year-old children had it; and about the same proportion of the older chronics had it as the younger cases.

Another impression I had was that obstruction was a causative factor in chronic infections of the region. Our chart would certainly seem to bear this impression strong support, for they are associated in practically every case.

The largest single group of patients from the standpoint of diagnosis were those of chronic suppurative disease, most of them with obstruction, while but few of them had polyps. The next most frequent group of cases diagnostically were those who did exhibit polyps; and of the cases that had polyps, most of them

were asthmatics. But there were twenty-five cases of asthma, not all of whom had polyps.

Many of the acute cases were under observation but a very short time. On the other hand, there are numerous cases of chronic disease which have been under observation for eight, ten, and twelve years, and one for sixteen years, after operation.

As for the immediate outcome of the operation itself, that is, until healing of the area of operation has taken place, there are six of the patients who had only a fair result. By that we mean that healing itself was accompanied by some untoward circumstance, such as supuration of the retained clots, undue discomfort, or continued oozing of blood. There were seven cases that had post-operative hemorrhage of sufficient volume to be noted. Three patients had severe hemorrhage, but not severe enough to need transfusion.

Of the distressing complications of operation, three caused us considerable concern. In one case the tip of the hooked knife broke off within the right sphenoid sinus. One case was complicated by a severe cellulitis of the face; this was due to infection spreading from the nose in a case in which there was an infected cell anterior to the infundibulum. One case was complicated by emphysema of the face and neck; this was quite worrisome. There were no fatalities.

One patient, however, was a spectacle of what not to do, and I am not sure that I would not repeat the same error, given like circumstances. She had been admitted to the hospital in an extremely severe attack of asthma of but three days' duration. She had never had previous attacks. Not any remedy would relieve the spasm; the physician even tried chloroform in desperation. Cocaine applications in the nose seemed to relieve her somewhat, and when this was observed, after adding more cocaine to the

first dose, we did a bilateral ethmo-sphenoid operation, and she seemed improved for about two days, though she was far from well. Then suddenly she became very much worse and died in a few hours in status asthmaticus. Autopsy was done to assure us that she had not died as a direct result of the operation itself.

The most frequent symptom in the matter of recurrence was polyps. There were 29 cases who exhibited polyps before operation. There were 18 recurrences of polyps; but not all of these had had polyps at the time of operation. Again, of these 18 recurrent polyps, 11 were reoperated, and two patients were operated a third time.

Of the 25 cases of asthma, there were nine recurrences, of which three were not reoperated because they would not submit. These three patients still have their asthma since the recurrence of the disease in the sinuses, in spite of accepting treatments from other sources. All of the recurrences of asthma except one were in patients who had had polypoid degeneration. This one exception is a most satisfactory case, a physician's wife who has been under observation for fifteen years. After her first operation, she was asthma-free for

five years. In 1932 we removed a polyp from about the mid-portion of the left ethmoid region, which seemed to have its attachment at the lateral edge of the cribiform plate. Since then, with every cold, this area becomes inflamed. If she has an attack of asthma, a single crystal of cocaine touched to this spot stops the attack of asthma for that period.

Three of our cases which were reoperated were done in order to open a single cell, either anterior to the infundibulum, or far posteriorly. These unusual anatomic structures are not always discernable at the time of operation.

In the group are two patients whose physicians urged operation upon us in an attempt to clear up what they said was encephalitis. Both patients suffered severe headaches. Both operations were done under protest. Neither of them had any pathology that could be located at operation, and both of them suffered recurrence of the headache as soon as the post-operative anodyne was dissipated.

There were seven cases whose indication for operation was retro-bulbar neuritis. None of them was of long duration, all of them cleared up quickly, and in no instance was there a residual loss of vision.

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SKIN TEST FOR PREGNANCY

An intradermal injection of a colostrum solution gave no reaction in 98 per cent of 265 pregnant women. Nonpregnant women reacted to similar injections with the formation of a characteristic weal and areola in 96 per cent of cases. Males reacted similarly to nonpregnant females. Children before puberty, on the other hand, reacted similarly to pregnant women.—Frederick H. Falls, M.D., Vincent C. Freda, M.D., and Harold H. Cohen, M.S., *Am. J. Obst. & Gynec.*, 41:431-438, March, 1941 (Clinical Abstracts).

BENZEDRINE FOR DYSMENORRHEA

Amphetamine (Benzedrine) sulfate, in doses of 5 to 20 mg. a day, was used in the treatment of 34 cases of essential dysmenorrhea. The drug relieved pain, fatigue and depression in cases in which other measures had failed. This finding was confirmed by the substitution of placebos during alternate periods.

It is concluded that amphetamine sulfate is a valuable drug for the treatment of functional dysmenorrhea and that it is well adapted to ambulatory patients.—Z. E. Taylor, *New England Med. Journ.*, 1941 (Clinical Abstracts).

PHYSICAL THERAPY IN PERIPHERAL VASCULAR DISEASE*

By B. S. TROEDSSON, M.D., Orange, N. J.

To evaluate the relative merits of one physical therapeutic procedure as compared with another is difficult, requiring controlled conditions, a great number of cases, and observations over a long period of time. Such studies are available to us practically in only one procedure; namely, the use of alternating negative and positive air pressures to the extremities, popularly called the "Pavaex treatment". This mechanical device was originally advanced independently by Herrman and Reid,^{1,2,3} and by Landis and Gibbon.^{4,5} Although the treatment has aroused great interest and has been subject to a tremendous amount of investigation, it is impossible to assign to it a definite and specific place in the management of peripheral vascular diseases. Allen and Brown⁶ concluded that simpler measures could accomplish the same results. Wilson and Broome,⁷ reporting on a series of cases of arteriosclerosis, thrombo-angiitis and embolism, adopted a negative attitude as to the value of passive vascular exercises. Using the Herrman cycle, only 5 of 12 cases of arteriosclerotic peripheral vascular disease were somewhat improved. Only 2 of 7 cases of thrombo-angiitis obliterans showed slight decrease in intermittent claudication. De Takats⁸ maintains that Buerger's disease is not strikingly influenced by alternating pressure. He advanced the idea that pravaex treatments, in addition to a negative and positive pressure effect, also may create an intermittent venous hyperemia by the action of the cuff. He found that even negative and positive cycles seemed to maintain the venous oxygen best. Theis and Freeland⁹ concluded that combining reflex dilatation by means of heat with pressure treatments is distinctly of more clinical value than either measure alone. Conway,¹⁰ using the Herrman cycle, reported improvements in 80 per cent of patients with arteriosclerosis affecting the major and secondary arteries of the extremity. They were treated from 3 to 6

months. In 9 of 10 cases of sudden vascular occlusion the treatment was effective. In 4 cases of thrombo-angiitis obliterans no benefit was noted. Passive vascular exercises were employed without other treatment save the incision of the skin, the care of the nails, and other simple measures. Without Pavaex treatments, Bernheim and London¹¹ reported 84 per cent of cases of arteriosclerosis and 79 per cent of cases of thrombo-angiitis obliterans showed improvement. In addition to the medical management, physical therapy was used in the form of Buerger's exercises and warm soaks. Very light massage was also allowed.

Thus it appears that the actual value of the Pavaex treatment still has to be determined. Possible conditions in which the treatment would be indicated are arteriosclerosis with predominant involvement of the major and secondary arteries, acute arterial occlusion due to embolism, thrombosis, traumatism or operative ligation of major vessels and acute peripheral circulatory stasis as in frostbite. When this treatment is elected, the greatest number of hours possible in the shortest time should be given. The Herrman cycle and pressures are tolerated best by the patient. The extremity should be placed at the level at which the healthiest color is observed. The cuff should

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2. Herrman, L. G., and Reid, M. R.: The Conservative Treatment of Arteriosclerotic Peripheral Vascular Disease. *Annals of Surgery*, Oct., 1934.

3. Herrman, L. G.: Passive Vascular Exercises. J. B. Lippincott & Co., Phila., 1936.

4. Landis, E. M., and Gibbon, J. H. Jr.: Effects of Alternate Suction and Pressure on Circulation in Lower Extremities. *Proc. Soc. Exper. Biol. and Med.*, 30:593, February, 1933.

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6. Allen, E. V., and Brown, G. C.: Intermittent Pressure and Suction. *J. A. M. A.*, 105:25, p. 2029, Dec. 2, 1935.

7. Wilson, H., and Broome, N. W.: Passive Vascular Exercises. *J. A. M. A.*, Vol. 106:22, p. 1885, May 30, 1936.

8. De Takats, G.; Hick, F. K., and Coulter, J. S.: Intermittent Venous Hyperemia in the Treatment of Peripheral Vascular Disease. *J. A. M. A.*, Vol. 108:23, p. 1951, June 5, 1937.

9. Theis, F. V., and Freeland, M. R.: Peripheral Circulatory Diseases. *J. A. M. A.*, 107:14, p. 1097, Oct. 3, 1936.

10. Conway, J. H.: Obliterative Vascular Disease. *J. A. M. A.*, Vol. 106:14, p. 1153, April 4, 1936.

11. Bernheim, Alice R., and London, Isahel M.: Arteriosclerosis and Thrombo-angiitis Obliterans. *J. A. M. A.*, Vol. 108:25, p. 2102, June 19, 1937.

* Presented at the Annual Meeting of The Medical Society of New Jersey, May 20, 1941.

be so adjusted that during the positive phase it is barely airtight. An electric heating pad should be wrapped around one of the good extremities for the production of vasodilatation by reflex action. The pressures should be adjusted so that a flushing of the skin is noticeable during the negative phase and a blanching during the positive. It is only with these precautions that the best results can be obtained. To make the treatment mechanical and not individualized invites disrepute.

VENOUS OCCLUSION APPARATUS

In addition to the suction-pressure boot there are on the market, many mechanical devices based on physiologic or mechanical principles, said to be of value in peripheral vascular diseases. One is the intermittent venous occlusion apparatus advocated by Collins and Wilensky.^{12,13} This consists simply of a blood pressure cuff connected to an airpump that can be set to alternately inflating the cuff to a certain pressure for a given time, and then releasing the pressure for a certain time. The pressure advocated is 10-15 mm. below the diastolic blood pressure and four cycles are available, varying from 1 minute compression, 2 minutes release to 4 minutes compression and 2 minutes release. The Work of Collins and Wilensky was to some extent immediately questioned by Samuels.¹⁴ Wright¹⁵ discontinued its use as a routine measure after extensive trial. McKittrick,¹⁶ however, thinks it is practical for the treatment of peripheral vascular diseases. My own experience with this apparatus is very limited and I can in no way pass judgment on it.

12. Collins, W. S., and Wilensky, N. D.: Intermittent Venous Compression in the Treatment of Peripheral Vascular Disease. *Am. Heart Jour.*, 11:705, June, 1936.

13. Collins, W. S., and Wilensky, N. D.: The Treatment of Peripheral Obliterative Arterial Diseases. *J. A. M. A.*, Vol. 107:24, p. 1960, Dec. 12, 1936.

14. Samuels, S. S.: Thrombo-angiitis Obliterans. *J. A. M. A.*, Vol. 108:5, p. 411, Jan. 30, 1937.

15. Wright, I.: Conservative Treatment of Occlusive Arterial Disease. *Arch. Surg.*, 40:163-189, Feb., 1940.

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17. Sanders, C. E.: Cardiovascular and Peripheral Vascular Diseases; Treatment by Motorized Oscillating Bed. *J. A. M. A.*, 106:916, 1936.

18. Barker, N. W., and Roth, G. M.: Treatment of Occlusive Arterial Disease of Legs by Means of Sanders Vaso-scillator (Sanders' Bed). *Am. Heart Jour.*, 18:312-316, Sept., 1939.

TRIPHASIC CYCLE

De Takats,⁸ et al., have recommended a third method of treating peripheral vascular diseases. They adopted a triphasic cycle consisting of:

1. Elevation of the extremity for 1 minute.
2. Venous compression until rubor appears.
3. Horizontal position followed by release for a period twice the venous compression less 1 minute.

The venous compression pressure should not exceed 60 to 90 mm. of mercury—the diastolic pressure—of the extremity at the elevated level. If edema, cyanosis, ulceration or gangrene is present, the pressure should not exceed 40 mm. of mercury. De Takats appears to be the only one who has had experience with this form of treatment, and judgment has to be withheld until further work has been done.

THE SANDERS BED

The Sanders Bed¹⁷ essentially reproduces the action of Buerger's exercises in a more efficient manner and without any effort on the part of the patient. The cycles of the bed should be adjusted so that blanching is barely produced in the up-tilt position and rubor in the down-tilt position. The bed is a useful device and may be used wherever Buerger's exercises are indicated. Barker and Roth¹⁸ found that it would relieve pretrophic pain, the pain of ischemic neuritis and the pain of ulceration and gangrene. The pain of intermittent claudication was unaffected, however.

THERMAL DEVICES

Thermal devices are used to obtain the physiologic response of either cold or heat. Cold is used little except in the form of icebag applications in acute phlebitis, the cold bath in the contrast bath, and for desensitization purposes in cold allergy. Snow is often used with massage to revive frozen parts.

Heat devices are more numerous. The hot-water bottle and the electric pad are the simplest. They should be applied only to the unaffected parts—to give their action by reflex vasodilatation. The stomach or the arm is the favorite site of application in case of lower

extremity disease. For the application of heat directly to the affected extremities many procedures are available. Either moist or dry heat can be used. Hot soaks of either plain water, boric acid or normal saline solution of a temperature of 96° to 100° for 15 to 30 minutes can be carried out by the patient and are recommended by Bernheim and London,¹¹ and by Wright.¹⁵ Contrast baths consist of immersing the distal half of the extremity alternately in water of 104° to 108° for 3 to 5 minutes and in water of 50° to 70° F. very briefly. This is done several times and is finished with a brisk drying after a hot immersion to obtain good circulatory response. Wright¹⁹ uses the Sitz bath, in which the patient sits with his pelvis and part of his thighs immersed in water with a temperature of 100° to 105° for 20 to 30 minutes. The Nauheim bath, found in spas, is used in moderate circulatory impairment. The whirlpool bath, found in most hospitals, consists of whirling, aerated water with a temperature of 100° to 105° F. In my experience these baths, given for 20 to 30 minutes and followed by massage, have been preferred by patients with thrombo-angiitis obliterans. They appear to give more relief than boot treatments or applications of dry heat for a corresponding period of time. If ulcerated areas are present they should be dried out after the treatment by a very short and mild application of radiant heat.

Direct dry heat is obtained by radiant heat bulbs or elements in heat cradles, applied over the patient's affected extremities. The cradle should be thermostatically controlled and set at 90° F. It is the only extensively used heat device about which there is no controversy. Bernheim and London¹¹ failed to see good results from the use of diathermy and "baking". Wright¹⁹ condemns local use of heat lamps, diathermy or short-wave machines. On the other hand, Perowe²⁰ concluded from his results that diathermy is of definite value in the treatment of peripheral-vascular disturbances, especially in arteriosclerotic ischemia without gangrene, and that diathermy improved the circulation largely by relieving vasospasms.

My own experience confirms the findings of Perowe, and I have no hesitation in using the

above devices in selected cases. I believe, however, that to be of value the devices must be used by men familiar with the apparatus as well as with peripheral vascular diseases. In the home or in the hands of inexperienced persons they are dangerous.

IONTOPHORESIS

Iontophoresis with acetyl-beta-methylcholine was introduced by Kovacs.²¹ The drug is applied to the positive pole of a galvanic current and follows the current into the tissues. The procedure has been advocated for use in chronic varicose and post-phlebitic ulcers.

EXERCISE

Buerger's exercises are extensively used. They consist of elevating the legs and resting them on a 45° to 60° plane until blanching appears, then sitting up and hanging them over the edge of the bed until rubor appears or the veins are filled. This is followed by rest in the horizontal position for 30 to 60 seconds. This cycle is repeated for 20 minutes several times during the day. The tendency is to prescribe these exercises in a fixed manner as for instance, 1 minute up, 1 minute down, and 1 minute rest; or 3 minutes up, 3 minutes down and 3 minutes rest. This is wrong. The exercises should be individualized and the time determined by the blanching and rubor in some cases, and in others by the venous emptying and the venous filling time. Allen has modified the Buerger's exercises by having the patient actively perform, with the feet in the dependent phase, ankle flexion and extension, inversion and eversion and toe movements. Other exercises employed, aside from Buerger's, are bicycle exercises, which the patient performs lying flat on his back.

MASSAGE

Massage is seldom mentioned in modern treatises on peripheral vascular diseases; but it is of great value. Massage increases the circu-

19. Wright, I. S.: Physical Therapy in Peripheral Vascular Disease. *Arch. of Phys. Therapy*, 19:16, March, 1938.

20. Perlow, Samuel: Local Diathermy in Peripheral Circulatory Disturbances. *J. A. M. A.*, Vol. 104:24, Dec. 9, 1933.

21. Kovacs, Joseph: Iontophoresis of Varicose Ulcers. *Arch. of Phys. Therapy*, 18:103-106, Feb., 1937.

22. Smith, B. C.: Physical Therapy of Peripheral Vascular Disease. *Arch. of Phys. Therapy*, 18:391, July, 1937.

lation in the skin and muscles. It helps to limit and break up fibrous tissue formations, which are the by-products of inflammation and cause circulatory obstruction. Proximal segments of the affected extremities should be treated first and as the circulation improves in these, advance distally with the treatment. To use massage properly requires skill and experience. Personally, I very seldom prescribe massage by itself but use it extensively following the boot treatment or after the application of heat in one form or another. Smith²² recommends

such combination treatment. He states, "In the past four years 275 patients, all in advanced stage, totalled 3,380 visits to the clinic. Most treatments have been carried out in the physical therapy department. Of these 275 patients only 2 who came to the clinic without gangrene have developed this condition and required amputation. Both were thrombo-angiitis obliterans and verged upon gangrene on admission. These facts manifest the aid physical therapy has rendered patients with peripheral vascular diseases."

SUMMARY

Physical therapeutic devices and procedures for the treatment of peripheral vascular diseases have been reviewed. To determine their absolute and their relative value is extremely difficult. All are based on some physiologic or pathologic fact and thus justified. Their proper

and timely application requires knowledge and experience in the use of the procedures, and in the treatment of the diseases. Thus used, many of them are of great value in some phase of the treatment of peripheral vascular diseases.

424 Heywood Avenue

HEALTH PRESERVATION DECALOGUE

1. The basis of good medical practice—THE PERIODIC HEALTH EXAMINATION!
2. Specialism has wrought serious changes, and it is incumbent on the practicing physician to attempt to win back the confidence of the public in "general medicine".
3. The true physician, faithful to the ancient traditions of medicine, will devote as much time to prevention as to cure.
4. Prosperity walks hand in hand with the physician who gives intelligent and efficient preventive medical service.
5. The public must be educated to the value of the Periodic Health Examination. It is the physician's duty to educate his personal patients.
6. A sick person will call in as his physician
- that doctor who has examined him at regular intervals.
7. A thorough examination at regular intervals instills, in the patient's mind, confidence in the future and in his doctor.
8. The discovery of surgical conditions in the earlier safe decades will prevent unnecessary surgical deaths by timely operation.
9. Few serious and disabling diseases begin acutely, and many have no premonitory or characteristic symptoms. Only a physician can discover them through a Periodic Health Examination.
10. Health Examinations need not conflict with a physician's other engagements. They may be arranged to fill the slower office hours.

—Philadelphia Weekly Roster.

NEW JERSEY MATERNAL MORTALITY STATISTICS — 1931-1940

MATERNAL WELFARE ARTICLE NUMBER SIXTY-ONE

By ARTHUR W. BINGHAM, M.D., East Orange, N. J.

Chairman, Committee on Maternal Welfare of The Medical Society of New Jersey; and
Chief Advisory Obstetrician, Bureau of Maternal and Child Health,
State Department of Health.

This is the first of a series of articles illustrated with maps and graphs showing the results of the work in the various counties according to the different mortality classifications.

The publication of the maternal mortality statistics of New Jersey for 1940 concludes ten years of organized maternal welfare work in this State. The maternal mortality rate for 1931 was 59 per ten thousand live births while for 1940 it was 29, a reduction of 50 per cent (Fig. 1). The solid line shows the rates for the State as a whole, the dashes show the rates for the urban counties, and the dotted line shows the rates for the rural counties.

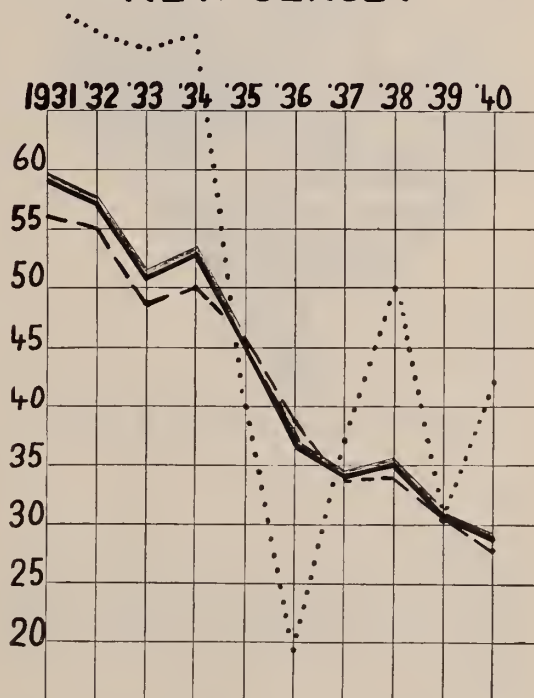
Let us compare the rates for the chief causes of maternal deaths. Rates are all per ten thousand live births. Death rate for puerperal septicemia was 16 in 1933 and 4.2 in 1940, a reduction of 75 per cent. The year 1933 is selected as the base, because septic abortions for the first time were given a separate classification from septicemia in 1933. Death rate for septic abortion was 4.1 in 1933 and 6.3 in 1940, an increase of 50 per cent. This increase is due in part to the fact that criminal abortions have been listed as maternal deaths only since January 1, 1940. They had previously been classified as homicides.

The rate for albuminuria and eclampsia was 5.8 in 1933 and 3.2 in 1940, a reduction of 46 per cent. It was in 1933 for the first time that other toxemias were separated from albuminuria and eclampsia. Death rate for puerperal hemorrhage was 7.4 in 1931 and 3.0 in 1940, a reduction of 60 per cent. Death rate for Other Accidents of Childbirth was 9.6 in 1931 and 5.9 in 1940, a reduction of 39 per cent. The rate for "milk leg" and embolism was 4.9 in 1931 and 2.5 in 1940, a reduction of 50 per cent. The rate for Other Accidents of Pregnancy was 5.3 in 1931 and 1.3 in 1940, a reduction of 75 per cent.

The only rate which has not improved is that of septic abortion. The figure which shows least improvement is "Other Accidents of Childbirth".

MATERNAL MORTALITY RATES

NEW JERSEY



STATE RATE — RURAL COUNTIES..... URBAN--
RATES ARE PER 10,000 LIVE BIRTHS

FIGURE 1

MATERNAL MORTALITY RATES BY COUNTIES

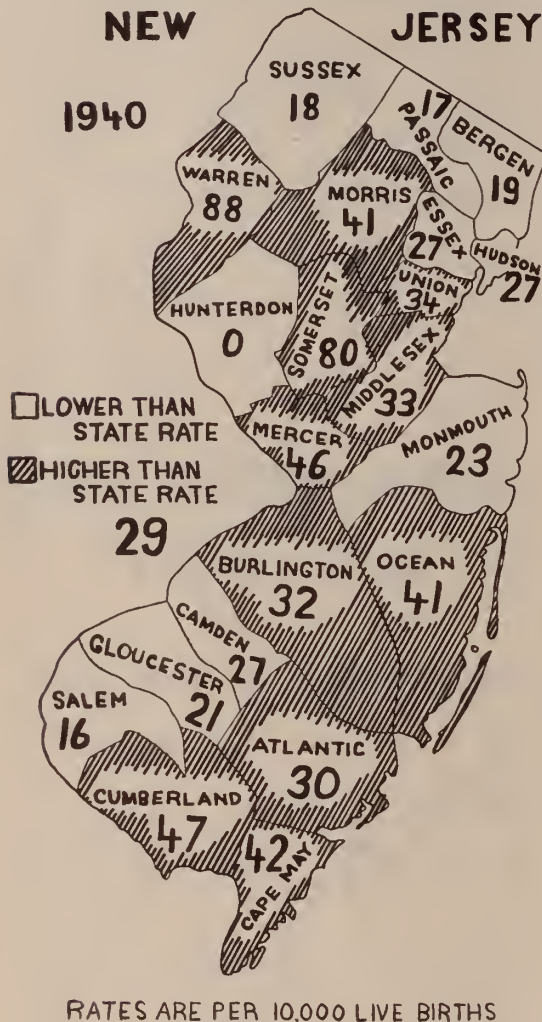


FIGURE 2

Figure 2 shows the mortality rate for 1940, distributed by counties. This annual map should be used by individual counties for their own comparative studies of progress from year to year.

As the annual number of live births varies in the counties from about 275 to about 12,000, the three-year period (Figure 3) is used for a comparative study of the rates of the different counties. As each county has different problems, the county committees should study

MATERNAL MORTALITY RATES BY COUNTIES

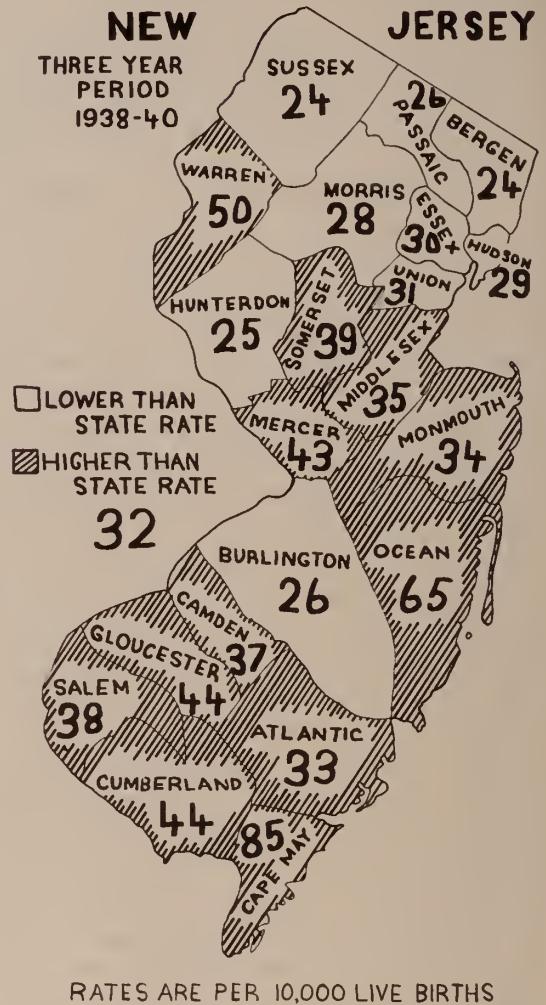


FIGURE 3

these statistics and devise means of improving them.

Figure 4 is a record of the counties for 1940 according to the five principal causes of death, indicating whether they were higher or lower than the rate for the State as a whole.

DEATH CERTIFICATES

Many death certificates are filled out carelessly, making it difficult to classify the death correctly. More care should be taken to give

accurate information on death certificates. Certificates prepared by interns should be checked by the attending obstetrician in charge of the case. Such a rule was made by the State Committee on Maternal Welfare a few years ago but a number of hospitals still pay no attention to it.

RECORD OF COUNTIES 1940 PRINCIPAL CLASSIFICATIONS

	PUERPERAL SEPTICEMIA	SEPTIC ABORTIONS	TOXEMIAS OF PREGNANCY	HEMORRHAGE	OTHER ACCIDENTS OF CHILDBIRTH	WHITE	SHADED
ATLANTIC						4	1
BERGEN						3	2
BURLINGTON						3	2
CAMDEN						3	2
CAPE MAY						4	1
CUMBERLAND						2	3
ESSEX						2	3
GLOUCESTER						3	2
HUDSON						3	2
HUNTERDON						5	0
MERCER						1	4
MIDDLESEX						3	2
MONMOUTH						3	2
MORRIS						1	4
OCEAN						4	1
PASSAIC						5	0
SALEM						4	1
SOMERSET						1	4
SUSSEX						5	0
UNION						2	3
WARREN						2	3

WHITE BLOCKS — LOWER THAN STATE RATE

SHADED BLOCKS — HIGHER THAN STATE RATE

FIGURE 4

SOURCES OF DATA

Histories of deaths connected with pregnancy are obtained by the field physicians. The findings of the course of the case and the procedures used have proved most valuable in providing material for study and discussion at obstetrical conferences. It also makes it possible to classify the deaths more accurately. In charging the death to any county the residence of the patient and physician as well as the county in which the complication occurred are considered.

The excellent coöperation of the hospitals in giving the field physicians facts regarding maternal deaths and in sending in their annual reports promptly is greatly appreciated by the State Committee on Maternal Welfare.

OBSTETRICAL CONFERENCES

Many of the counties have obstetrical conferences. Experience has proved that the obstetrical conference, at which histories of cases and conditions in the counties are studied, is an invaluable means of post-graduate education. It is not necessary to leave one's practice to attend the meetings and facts are always brought out which may prove of value when a similar case is met.

HOSPITAL BIRTHS

The number of births in hospitals has gradually increased each year. In 1940, 85 per cent of the births in New Jersey occurred in hospitals. The counties varied from 35 per cent in Hunterdon County, 51 per cent in Cape May County to 90 per cent in Bergen County, 91 per cent in Passaic County, 92 per cent in Hudson County and 93 per cent in Essex County.

As the largest proportion of births in urban counties occur in hospitals, the hospital staffs should study these statistics and check their services for any weak spots which may be present in order to improve these rates. They should check especially the conditions which lead to deaths from "Other Accidents of Childbirth". This classification includes anesthesia deaths, shock from difficult delivery, ruptured uterus,

cesareans, etc. The rate for this classification is too high in the urban counties.

The rural counties have too high a mortality rate for toxemias of pregnancy. This is due to lack of preventive prenatal care. Too often the patient neglects to see a physician early and regularly during pregnancy.

While the reduction in the maternal mortality rate is most gratifying, the study of cases brings out facts which indicate the possibility of further improvement. The following articles in this series will give more detail regarding the several classifications of maternal deaths.

A LESSON FROM A DEATH CERTIFICATE

NUMBER THIRTY-THREE

Patient pregnant with twins. Had good prenatal care. Near end of pregnancy had slight symptoms of beginning toxemia. No albumin in urine but a slight rise in the diastolic pressure, slight edema in one ankle, and marked gain in weight rather suddenly.

Patient delivered normally of twins, both living. Nine hours after delivery patient had a convulsion and later showed all signs of a

severe toxemia. She lived a few days and died after a severe convulsion.

This case indicates how a severe toxemia may develop in a patient showing few signs before delivery. In twin pregnancy this is more likely to happen, the toxemia growing rapidly worse during labor.

Danger signals should be watched for with special care in twin pregnancies.

A. W. BINGHAM, M.D.

THE HOSPITAL AND MATERNAL WELFARE

Hospitals exist not only to conserve and restore the health of individuals, but to contribute to improvement of maternal health by sociological, economic and intellectual activities. They must provide special organization and facilities for obstetric patients.

Management, executives and medical staff must cooperate in specially devised staff organization for control with reference to obstetric patients, according to S. A. Cosgrove, M.D., of Jersey City, N. J., in a recent issue of The Journal of the Michigan State Medical Society. This special organization should include competent consultation service; adequate safeguards for bleeding cases; special control of

forceps operations and establishment of technical routines in labor and delivery rooms.

These standards must be enforced rigidly and must apply to private patients as well as the public service. Prenatal and postnatal clinics and field nursing service must be set up and operated.

Finally, hospitals have a great educational responsibility with reference to the laity, to nurses, and most importantly, to physicians.

The last group includes its extern staff, its interns and its residents. To them such education should be an integral continuation of their medical college training.

STATE SOCIETY ACTIVITIES

MEDICAL PREPAREDNESS NOTES

INDUCTIONS AND REJECTIONS IN NEW JERSEY

One registrant out of every seven passed as physically fit by the local board is rejected by the medical team at the Trenton Induction Station. This appears from figures released by the Committee on Medical Preparedness which indicate that of 5,325 selectees examined in June, 697 or 13 per cent were rejected for medical reasons. This figure is comparable to the proportion of rejections by the civilian specialists who worked at the induction stations during the first six months. In that period, the civilian doctors on induction boards rejected 4,034 out of 28,005 selectees—a medical rejection of 14 per cent.

These findings easily give rise to two spurious interpretations. One is that the youth of the country is in poor physical condition; another that the physicians on local draft boards are careless examiners. Both conclusions are false, and no physician should allow such an interpretation to be made without swiftly correcting it.

Significance of the apparently "high" rejection rate: The encouraging finding is that so large a proportion of our youth is free of every physical or mental defect when examined without warning or effort at prehabilitation. Most of the "defects" are primary congenital, developmental or social, rather than medical in origin. For instance, "insufficient teeth", the number-one cause for rejection, speaks for financial inability or personal unwillingness to secure proper dentures rather than any defect in dental care itself. Again, refractive errors, second most common cause for rejection, arise out of our highly word-minded type of culture, associated with problems like poor lighting or financial or personal unwillingness to secure eye-glasses, rather than out of any deficiency in the care supplied by ophthalmologists. Conditions like tuberculosis show a gratifying decline when compared with the 1917 draft; at that time, tuberculosis caused 10 per cent of all rejections, a figure which has now tailspinned to less than two per cent. Finally, let it be remembered that the Army has asked for the cream of the crop, and that the standards are so high that only a practically perfect physical specimen will slip through the fine-comb of an induction examination.

Significance of the difference between draft boards' and induction boards' rejections: The local draft board doctors are, for the most part, general practitioners not expected to focus their attention sharply and exhaustively on any one body system; the draft boards know that a detailed specialized examination by a consultant will be available at the induction station, that the induction team is now composed of medical reserve officers thoroughly familiar with army requirements and giving a hundred per cent of their professional time to looking for the minutest defects—which can not be asked of draft board doctors. Considering all this, it is to the credit of the busy, unsalaried, part-time general practitioner that he manages to discover almost 90 per cent of the defects at his general preliminary examination.

Chief reason for psychiatric rejection was "psychoneurosis". Most of these would have been passed had there been no trained psychiatrist on the examining team. In fact, most of these "neurotics" were not disabled from ordinary civilian pursuits at all, although it was the considered opinion of army psychiatrists that they would not adjust well to the discipline, routine, sustained effort and strain of army life. These men can make better adjustments and serve their country well in civilian life. The correction of their neuroses is chiefly social, economic, educational or vocational rather than medical.

The prevalence of middle-ear disease is proof of the soundness of the position always taken by physicians that the infectious diseases and "minor" illnesses of childhood should be seen early and treated vigorously, precisely in order to prevent such complications.

Hypertension caused many rejections. This is one of the acknowledged problems of the medical profession, one which has long engaged the interest and attention of physicians. Certainly there has been no lack of effort in this field on the part of the medical profession.

Much has been heard of a "fifty per cent rejection rate". This figure is misleading, since it is computed by including deferments for all non-medical causes and for all minor defects along with genuine rejections. Actually almost

half of the recorded "rejections" are deferments for minor conditions which do not incapacitate the man from industrial defense or civilian work, and which in many cases, indeed, would not impair his military acceptability at some later date.

Further improvement in the health of this group, and indeed of all the people, is not so much a medical problem as one of sociologic, economic, educational and vocational importance. The medical profession may be counted upon to contribute its share towards the solution of the problem.

A complete analysis and summary of the causes for rejection is maintained in the office of the Committee for submission to the New Jersey Defense Council each month. Any physician may secure a copy of the analysis by writing to the Secretary of the Committee at the Trenton office (address below).

Following is a list of the induction personnel at the station in the 114th Infantry Armory in Trenton:

Commanding Officer: Major John Scially, Inf.
Induction Officer: Captain William R. Cohen, Inf.

Chief Medical Officer: Captain F. P. Guidotti, Med. Corps.
Supply Officer: Second Lieut. J. W. Leary, Inf.
Dentist: Capt. G. A. Arnold, Den.-Res.
Otorhinolaryngologist: Capt. M. W. Buchbinder, Med.-Res.
Radiologist: Capt. A. G. Cohen, Med.-Res.
Surgeon: Capt. P. S. Rolland, Med.-Res.
Roentgenologist: Lieut. H. Rosenzweig, Med.-Res.
Ophthalmologists: Lieuts. S. Schutz and L. L. Stein, Med.-Res.
Internists: Lieuts. A. J. Barbano and P. M. P'landaca, Med.-Res.
Pathologist: Lieut. H. R. Marcus, Med.-Res.
Orthopedist: Lieut. R. K. Earp, Med.-Res.
Neuropsychiatrists: Lieuts. R. N. Carrier, M. Dollin, S. Kahn and B. F. Vogel, Med.-Res.

The South New Jersey Recruiting District is commanded by Colonel F. Emannuelli, Inf. The Executive Officer is Major F. T. Madigan, Inf., and the Public Relations Officer is Major L. M. Allen, Inf.

Committee on Medical Preparedness,
Medical Society of New Jersey
143 East State Street, Trenton, N. J.

NUMBER OF CHILDREN RECEIVING FREE STATE BIOLOGICALS SINCE JULY 1, 1940

DIPHTHERIA TOXOID

County	Total to May 31	Month of June	Total to June 30	Average per Month
Atlantic	7191	46	7237	603.1
Bergen	2787	738	3525	293.7
Burlington	1008	153	1161	96.7
Camden	1323	805	2128	177.3
Cape May	54	6	60	5.
Cumberland	118	5	123	1.2
Essex	7761	805	8566	713.8
Gloucester	273	78	351	29.2
Hudson	4938	825	5763	480.2
Hunterdon	122	457	579	48.2
Mercer	2878	47	2926	243.7
Middlesex	629	22	651	54.2
Monmouth	1000	260	1260	105.
Morris	542	101	643	53.5
Ocean	177	32	209	17.4
Passaic	4039	1506	5545	462.1
Salem	865	34	899	74.9
Somerset	265	43	308	25.6
Sussex	15	3	18	1.5
Union	2393	914	3307	275.5
Warren	74	33	107	8.9
Totals	38452	6913	45365	3780.4

SMALLPOX VACCINE

County	Total to May 31	Month of June	Total to June 30	Average per Month
Atlantic	693	66	759	63.3
Bergen	1622	438	2060	171.6
Burlington	307	14	321	26.7
Camden	1374	117	1491	124.2
Cape May	103	14	117	9.7
Cumberland	153	10	163	13.5
Essex	6488	249	6737	561.4
Gloucester	251	16	267	22.2
Hudson	3411	133	3544	295.3
Hunterdon	26	3	29	2.4
Mercer	1149	60	1209	100.7
Middlesex	888	37	925	77.1
Monmouth	1096	47	1143	95.2
Morris	576	100	676	56.3
Ocean	21	16	37	3.1
Passaic	2567	791	3358	279.8
Salem	407	23	430	35.8
Somerset	156	11	167	13.9
Sussex	21	12	33	2.7
Union	1379	140	1519	126.5
Warren	221	68	289	24.1
Totals	22909	2365	25274	2106.1

WELFARE COMMITTEE MEETING

The first meeting of the Welfare Committee of the present administrative year will be held in Trenton on Sunday, September 14; time and place to be set later. A change has been made from the policy of announcing regular, scheduled meetings

a year in advance; in the future, the Welfare Committee will meet at the call of the Chairman. It is tentatively expected that four or five meetings a year will suffice.

BOARD OF MEDICAL EXAMINERS

Since December, 1940, the New Jersey Board of Medical Examiners has taken action against the following:

December, 1940, Philip Manna, an unlicensed chiropractor of New Brunswick, paid the penalty for practicing medicine without a license.

December, 1940, Michael Nogradi, an unlicensed chiropractor of New Brunswick, paid the penalty for practicing medicine without a license.

January 21st, 1941, Rose Finkel, a registered pharmacist of Lenola, paid the penalty for practicing medicine without a license.

January 30th, 1941, Louis Ringer, a registered pharmacist of Jersey City, paid the penalty for practicing medicine without a license.

February 4th, 1941, Richard S. Davis, M.D., of Philadelphia, paid the penalty for practicing medicine without a license. Dr. Davis had a place for the practice of his profession in Vineland.

February 4th, 1941, Charles Baumler of Paterson, whose license to practice chiropractic was revoked by the Board, paid the penalty for practicing medicine without a license.

February 18th, 1941, Frederick J. Pollari of Newark pleaded guilty to a charge of practicing medicine before the Judge of the First District Court of Newark. Pollari gave electric treatments, medicine and hypodermic injections.

February, 1941, Carl G. Lenaesus of Ridgewood, a masseur, served ten days in jail after having been found guilty of practicing medicine by the Judge of the First District Court of Paterson.

February 25th, 1941, Lillie Becker, a fortune teller of Camden, was found guilty of practicing medicine without a license by the Judge of the First District Court of Camden and sentenced to ten days in jail.

February 26th, 1941, Charles Schaefer, Sr., and Charles Schaefer, Jr., of Oaklyn, paid penalties for practicing medicine without a license. The Schaefer practice laying-on-of-hands.

This was the seventh case against Schaefer, Sr., and the fourth against Schaefer, Jr.

March, 1941, Leon Linsen, a licensed chiropractor of Bayonne, paid the penalty for continuing to practice without having obtained an annual certificate of registration.

March 19th, 1941, the license to practice midwifery of Mary Yergofsky of Trenton was revoked by the Board.

March 19th, 1941, the license to practice chiropractic of Charles Baumler of Paterson was restored by the Board.

March, 1941, Frank Bangham, a registered pharmacist of Jersey City, paid the penalty for practicing medicine without a license.

March, 1941, West A. Durfor of Haddon Heights, an unlicensed chiropractor, paid the penalty for practicing medicine without a license.

March, 1941, John D. McManamy, a masseur of Arlington, paid the penalty for practicing medicine without a license.

April 8th, 1941, Salvador J. Abbatiello, an unlicensed chiropractor of South Amboy, paid the penalty for practicing medicine without a license.

April 16th, 1941, the Board revoked the license to practice midwifery of Marie Duman-sky of Newark. On the same day the license to practice midwifery of Theresa Casella of Newark was also revoked.

May 7th, 1941, Randal J. Brown, a registered pharmacist of Trenton, paid the penalty for practicing medicine without a license. This is the fifth time Brown has paid a penalty.

May 7th, 1941, Howard Worne, a chemist of Newark, paid the penalty for practicing medicine without a license.

May 7th, 1941, Ella Stevens, a fortune teller of Old Bridge, paid the penalty for practicing medicine without a license.

May 26th, 1941, Charles Schaefer, Jr., of Oaklyn paid the penalty for practicing medicine without a license. This was the fifth time Schaefer paid a penalty.

E. S. HALLINGER, M.D., Secretary.

OBITUARIES

DR. FRANCIS REYNOLDS HAUSSLING

The Medical Society of New Jersey lost one of its Past Presidents on August 4, 1941, when Dr. Francis Reynolds Haussling of Newark died suddenly at the



Spring Lake home of his associate, Dr. William Crecca. Dr. Haussling who, in 1936, had been chosen President of The Medical Society of New Jersey, had been identified with civic and medical affairs in our state since 1904 when he opened his office in Newark. A graduate of Columbia

University's College of Physicians and Surgeons in 1901, he took the step—unusual in those days—of devoting three years to graduate study before entering private practice. After an internship at St. Luke's Hospital in New York, he became a resident at the Sloane Maternity Hospital, and in 1904 continued his studies in Vienna and Prague.

Dr. Haussling had been associated with many hospitals in Essex County. At both Newark City and Newark Memorial Hospitals he had been President of the Staff.

Always a leader in Organized Medicine, he served as President, not only of two hospitals and of The Medical Society of New Jersey, but also as President of the Essex County Medical Society and of the Academy of Medicine of Northern New Jersey.

His family has long been prominent in North Jersey civic affairs. Two of his uncles (Julius Lebkuecher and Jacob Haussling) were mayors of Newark; his father was a distinguished merchant in the community; his mother, who died in 1928, had been one of the founders of the Home for Incurables.

Dr. Haussling's interests touched many facets of

civic life. He had been a director of the United States Trust Company, a consultant to the State Board of Health, a Captain in the United States Army Medical Corps, and a charter-member of the Academy of Medicine.

DR. ALFRED M. ELWELL

Dr. Alfred M. Elwell, one of the senior members of the Camden County Medical Society, died at the wheel of his car on May 24, 1941. He was en route to Ocean City when he suffered a heart attack and died before medical aid could be summoned.

Dr. Elwell was graduated from the Medical School of the University of Pennsylvania in 1899, and had been practicing in Camden since the turn of the century. He was a well-known South Jersey otolaryngologist and was chief of the laryngologic service at the Cooper Hospital. Dr. Elwell was one of the early Diplomates of the American Board of Otolaryngology, and had been a member of The Medical Society of New Jersey for almost forty years.

DR. EDWIN H. VAN DEUSEN

Dr. Edwin H. Van Deusen, former President of the Cumberland County Medical Society, died March 21 at Orlando, Florida. Dr. Van Deusen, who was 81 years old, had been practicing medicine since 1881, and had been a member of The Medical Society of New Jersey since 1912. He was distinguished for many interests which made him a leading citizen of Cumberland County. For more than a decade he was President of the Vineland Historical Society. He was a member of the Vineland Library Board, and a leader of the Tioga Choral Society. Dr. Van Deusen was an enthusiastic baseball fan, and had been a member of the famous 1873 baseball team of the University of Pennsylvania. He was an emeritus member of the staffs of both the Newcomb and the Vineland Hospitals.

DECEASED PHYSICIANS—NEW JERSEY

Name	Age	Date of Death	Place of Death	Residence	Cause of Death
Halsey J. Ball	72	May 31, 1941	Cape May	Same	Arteriosclerosis
Charles C. Cooner	61	May 12, 1941	Vineland	Same	Apoplexy
Louis E. Deary	69	May 4, 1941	Bayonne	Same	Coronary occlusion
Alfred M. Elwell	64	May 24, 1941	Ocean City	Camden	Coronary thrombosis
Edwin I. Ives	55	May 20, 1941	Berkeley Heights	Same	Chronic myocarditis
Douglas C. Ramsey	81	May 22, 1941	New Providence	Same	Chronic myocarditis
Robert Schulman	60	May 15, 1941	Morristown	Same	Coronary thrombosis
Grant Sparks	68	May 26, 1941	Trenton	Pitman	Coronary occlusion

COUNTY SOCIETY REPORTS

HUNTERDON COUNTY

J. E. Shangold, M.D., Reporter

The New Jersey Sanitarium at Glen Gardner was the scene of the summer meeting of the *Hunterdon County Medical Society*, July 22. Nineteen members of the Society attended; guests included Dr. Norman M. Scott, Executive Assistant of The Medical Society of New Jersey; Dr. Henry A. Davidson, Editor of the *Journal*, and Dr. Henry B. Diverty, President of the Gloucester County Medical Society.

The President, Dr. Germaine, announced that Dr. Samuel B. English has been appointed Chairman of the County's Legislative Committee; Dr. Philip Baker, Chairman of the Committee on Public Health; Dr. I. R. Boothby, Chairman of the Committee on Medical Practice, and Dr. J. E. Shangold, Reporter.

Reporting for the Committee on Revision of the By-Laws, Dr. B. S. Fuhrmann read proposed changes in the by-laws, including a shift of the annual meeting date to April and a provision that the President-Elect take over the President's duties in the latter's absence. Dr. Fuhrmann was authorized, on motion, to have the proposed revision of the by-laws mimeographed and distributed to the members.

The paper of the afternoon was read by Dr. A. J. Stolow of the State Sanitarium staff, who spoke on the surgical treatment of pulmonary tuberculosis with especial reference to thoracoplasty. Dr. Stolow emphasized the importance of thoracoplasty in cases in which simple pneumothorax had been futile, and urged that the procedure be undertaken promptly. He stressed the fact that tuberculosis must not be thought of as an invariably chronic disease, indicating that it had numerous acute manifestations. These were considered especially amenable to surgical intervention. Among 52 patients subjected to thoracoplasty at Glen Gardner, 73 per

cent were eventually classed as "closed and negative", and the ultimate death rate was under 8 per cent. These results were far better than obtained in comparable cases by any other treatment techniques. Dr. Stolow's paper was illustrated by x-ray plates. The speaker listed the indications for thoracoplasty, outlined the technique and evaluated the results. In the discussion, Dr. Samuel B. English, Medical Director of the Sanitarium, pointed out that the gratifying fall in tuberculosis death rates during the last few decades was due not only to better isolation but also to the increasing use of "radical" surgical techniques.

At the conclusion of the scientific session, the members and guests enjoyed a tasty luncheon in the staff dining room.

MONMOUTH COUNTY

Murray Woronoff, M.D., Reporter

The annual June meeting of the *Monmouth County Medical Society* was held June 25th, 1941, at the Norwood Golf Club in Long Branch, N. J. It was in the form of an outing.

Schedule of events:

1-5:30 p.m.—Golf, tennis and horseshoe tournaments

5:30 p.m.—Soft ball game

Marlboro Hospital team vs. 1940 Society champions

8-9:30 p.m.—Dinner

9:30 p.m.—Prize awards.

The softball game was "a lot of fun". It made some of us realize our age.

Dinner was a gay party. Dr. Lowsley was among the guests.

There were enough prizes so that almost each one of us received one.

The outing was a huge success and we all enjoyed it.

SUPPLEMENTARY LIST OF MEMBERS NUMBER FOUR

to the

OFFICIAL LIST OF MEMBERS, MARCH 15, 1941

The figures in parentheses refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

ACTIVE MEMBERS

Alcaro, Joseph, 1 W. Blackwell st., Dover (14)
Brown, Harold W., 27 S. Fullerton av., Montclair (7)
Della Fera, Lucien F., 206 First av., Newark (7)
Giardina, John S., 341 Walnut st., Newark (7)
Harrington, Walter L., 104 S. Munn av., E. Orange (7)
Morton, David P., Overbrook Hosp., Cedar Grove (14)
Reinfeld, Abraham G., 354 Clinton av., Newark (7)

Rosen, Charles E., 1513 Palisade av., Union City (9)
Schaffer, Nathan, 172 S. Arlington av., E. Orange (7)

ASSOCIATE MEMBERS

Barbano, Alfred J., 114th Inf. Armory, Trenton (12)
Bases, Leonard, 204 Norwood av., Deal (13)
Van Riper, Wm. D., Englew'd Hosp., Englewood (2)

WOMAN'S AUXILIARY

COUNTY AUXILIARIES

Camden County

Reported by Mrs. E. R. Hirst

The *Woman's Auxiliary to the Camden County Medical Society* met at Medford Lake Lodge for the annual luncheon meeting on Thursday, May 1, with Mrs. Lawrence L. Glover presiding. Present were 82 members and guests, and also three guests of honor—Mrs. R. J. McDonald, State Auxiliary President, who extended greetings; Mrs. James Hunter, former State President, and Mrs. William Raleigh, former Camden County President.

Mrs. Oswald R. Carlander, recently elected State Auxiliary President, who is also President of New Jersey Division of American Association of University Women, complimented Mrs. Glover on her splendid work during the year, and asked for continued coöperation of the Auxiliary members.

Mrs. L. R. Wilson, Treasurer, read her report. The sum of \$378.40 was realized from the Fashion Show and Card Party, March 3. This report was accepted and filed.

Donations given to several Camden County organizations, as recommended by the Executive Board, amounted to \$317.00 and a reserve sum will be held for emergency. On motion, this recommendation was accepted by the Auxiliary.

Mrs. Glover gave a very inspirational retiring address, named the officers for the coming term, and presented the gavel to Mrs. George B. German, new President, who spoke briefly and asked for complete coöperation.

The Committee Chairmen and the Board now comprise the following, in addition to Mrs. German:

Mrs. Arthur L. Stone, President-Elect; Mrs. H. R. Tatem, Jr., First Vice-President; Mrs. Max L. Weimann, Second Vice-President; Mrs. William J. Scruggs, Third Vice-President; Mrs. Lester R. Wilson, Treasurer; Mrs. A. G. Pratt, Recording Secretary; Mrs. A. Girton Kinney, Corresponding Secretary, and Mrs. Glover and Mrs. O. R. Kline, Directors. Committee Chairmen are: Mrs. H. R. Tatem, Program; Mrs. A. J. Casselman, Public Re-

lations; Mrs. G. F. West, Membership; Mrs. William Braun, Finance; Mrs. A. H. Lippincott, Legislative; Mrs. R. S. Gamon, Hospitality; Mrs. E. C. Hessert, Printing; Mrs. E. R. Hirst, Public Health; Mrs. H. J. Dempsey, Widows and Orphans; Mrs. E. C. Pechin, Courtesy; Mrs. J. N. Barroway, Publicity; Mrs. R. R. Betancourt, Arts, Hobbies and Historian; Mrs. J. E. Roberts, Parliamentarian; and Mrs. T. P. McConaghy, Librarian.

Delegates to attend the State Conference from the County Auxiliary are Mrs. German, Mrs. Arthur L. Stone, Mrs. Gamon, Mrs. T. K. Lewis and Mrs. Tatem. Alternates include Mrs. Weimann, Mrs. Casselman, Mrs. O. W. Saunders, Mrs. J. E. Roberts and Mrs. Betancourt. Mrs. Glover will attend as retiring President. Mrs. A. H. Lippincott was named alternate.

Mrs. R. S. Gamon, in charge of program, presented Mrs. A. H. Lippincott, who gave the dramatic reading "Sketches from the Life of the Day Family". Mrs. Frances C. Campbell, singer and violinist, and Mrs. Dorothy Moran, pianist, were heard in delightful selections.

Mrs. A. H. Lippincott presented the Auxiliary Pin to Mrs. Glover, making her a "Fellowette" in the County Auxiliary. Mrs. Glover thanked Mrs. Lippincott and all the Auxiliary members.

Meeting adjourned at 4 o'clock.

Union County

Reported by Mrs. Roland P. Blythe

The *Woman's Auxiliary to the Union County Medical Society* concluded the season's activities on June 3 with a luncheon and bridge party at the Suburban Club in Elizabeth. About 37 members and guests were present and were welcomed by the new President, Mrs. George Knauer of Elizabeth.

A gold pin was presented to Mrs. H. S. Murphy, of Roselle, retiring President.

Mrs. William C. Meinecke, of Roselle, was in charge of arrangements assisted by Mrs. C. G. Hanson and Mrs. Knauer.

BOOKS RECEIVED

ORBITAL TUMORS; results following the transcranial operative attack. By Walter E. Dandy, M.D. Pp. 168. New York, Oskar Piest. 1941. \$5.00.

HEALING CULTS; a study of sectarian medical practice; its extent, causes and control. By Louis S. Reed, Ph.D. Pp. 134. Chicago, University of Chicago Press. 1932. \$2.00.

X-RAY THERAPY OF CHRONIC ARTHRITIS (including the x-ray diagnosis of the disease). Preliminary report based on 100 patients treated at Quincy, Illinois. By Karl Goldhamer, M.D., with a foreword by Harold Swanberg, B.S., M.D. 24 original illus. by the author, 2 roentgenograms, and four tables. Quincy, Ill., Radiologic Review Pub. Co. 1941. \$2.00.

ESSENTIALS OF APPLIED MEDICAL LABORATORY TECHNIC. Details of how to build and conduct an office or small hospital laboratory at small cost. By J. M. Feder, M.D. Blood and Plasma Transfusion, by John Elliott, Sc.D. Pp. 241, illustrated. Two color plates. Charlotte, N. C., Charlotte Medical Press. 1940.

DOCTOR TAKES A HOLIDAY; an autobiographical fragment. By Mary McKibben-Harper, M.D. Pp. 249. Cedar Rapids, Iowa, Torch Press. 1941. \$2.50.

OUTLINES OF INDUSTRIAL MEDICAL PRACTICE. By Howard E. Collier, M.D. (Edin.), Ch.B. Pp. 440. Baltimore, Wm. Wood-Williams & Wilkins Co. 1941. \$5.00.

THERAPY OF THE NEUROSES AND PSYCHOSES; a socio-psycho-biologic analysis and resynthesis. By Samuel Henry Kraines. Pp. 512. Philadelphia, Lea & Febiger. 1941. \$5.50.

MANUAL OF CLINICAL CHEMISTRY. By Miriam Reiner, M.Sc. Introduction by Henry Sobotka, Ph.D. Pp. 291. New York, Interscience Press. 1941. \$3.00.

AVITAMINOSES, the Chemical, Clinical and Pathological Aspects of the Vitamin Deficiency Diseases. By Walter H. Eddy and Gilbert Dalldorf. 2d ed. Pp. 519. Baltimore, Williams & Wilkins Co. 1941. \$4.50.

TECHNIQUES OF CONCEPTION CONTROL. By Robert L. Dickinson, M.D., and Woodbridge E. Morris, M.D. A practical manual issued by the Birth Control Federation of America, Inc. Pp. 56. Baltimore, Williams & Wilkins Co. 1941. \$5.00.

MASK OF SANITY. By Hervey Cleckley, B.S., B.A., M.D. Pp. 298. St. Louis, C. V. Mosby Co. 1941. \$3.00.

MANUAL FOR DIABETIC PATIENTS. By Elliott P. Joslin, M.D. Pp. 238. Philadelphia, Lea & Febiger. 1941. \$2.00.

CARDIAC CLASSICS: a collection of classic works on the heart and circulation with comprehensive biographic accounts of the authors. Fifty-two contributions by fifty-one authors. By Frederick A. Willius, M.D., and Thomas E. Keys. Pp. 858 with 102 illus. St. Louis, C. V. Mosby Company. 1941. \$10.00.

TEXTBOOK OF MEDICINE. By various authors, edited by J. J. Conybeare, M.D. 5th ed. Pp. 1131, 24 illus. and 31 x-ray plates. Baltimore, Williams & Wilkins. 1940. \$7.50.

SYNOPSIS OF DISEASES OF THE HEART AND ARTERIES. By George R. Herrmann, M.D. 2d ed. Pp. 468. St. Louis, C. V. Mosby Co. 1941. \$5.00.

PSEUDO-ISOCROMATIC PLATES FOR TESTING COLOR PERCEPTION. 21 color plates and illustrations. Southbridge, Mass., American Optical Co. 1940. \$9.00.

ACCIDENTAL INJURIES; the medico-legal aspects of workmen's compensation and public liability. By Henry H. Kessler, M.D. 2d ed. Pp. 803. Philadelphia, Lea & Febiger. 1941. \$10.00.

PLAY FOR CONVALESCENT CHILDREN IN HOSPITALS AND AT HOME. By Anne Marie Smith. Pp. 133. New York, A. S. Barnes & Co. 1941. \$1.60.

TEXTBOOK OF PEDIATRICS. By J. Crozer Griffith and A. Graeme Mitchell. 3rd ed. Pp. 991. Philadelphia and London, W. B. Saunders. 1941. \$10.00.

PHYSICAL MEDICINE: The Employment of Physical Agents for Diagnosis and Therapy. By Frank H. Krusen. Pp. 846. Philadelphia, W. B. Saunders. 1941. \$10.00.

STORY OF CLINICAL PULMONARY TUBERCULOSIS. By Lawrason Brown. Pp. 411. Baltimore, Williams and Wilkins. 1941. \$2.75.

TEXTBOOK OF MEDICINE, by various authors. Ed. by J. J. Conybeare, M.C., D.M., Oxon., F.R.C.P. 5th ed. Pp. 1131. Baltimore, Wm. Wood. 1940. \$7.50.

ROENTGEN INTERPRETATION. By George W. Holmes, M.D., and Howard E. Ruggles, M.D. 6th ed. Pp. 364. Philadelphia, Lea. 1941. \$5.00.

FIRST AID IN EMERGENCIES. By Eldridge L. Eliason, M.D. 10th ed. Philadelphia, Lippincott. 1938. \$1.75.

STRANGE MALADY: The How and Why of Being Allergic. By Warren T. Vaughan. N. Y. Doubleday, Doran. 1941. \$3.00.

START TODAY; your guide to physical fitness. By C. Ward Crampton, M.D. Pp. 224. New York, A. S. Barnes & Co. 1941. \$1.75.

PRIMER FOR DIABETIC PATIENTS; an outline of treatment for diabetes with diet, insulin and protamine-zinc insulin including directions and charts for the use of physicians in planning diet prescriptions. By Russell M. Wilder, M.D. 7th ed. Pp. 184. Philadelphia, W. B. Saunders. 1941. \$1.75.

INFANTILE PARALYSIS, anterior poliomyelitis. By Philip Lewin, M.D. Illus. by Harold Laufman, M.D. Pp. 372. Philadelphia, W. B. Saunders. 1941. \$6.00.

AMERICAN ILLUSTRATED MEDICAL DICTIONARY. By W. A. Newman Dorland, A.M., M.D., with the collaboration of E. C. L. Miller, M.D. 19th ed. Philadelphia, W. B. Saunders Co. 1941. Pp. 1647. Plain, \$7.00. Thumb-indexed \$7.50.

ELECTROCARDIOGRAPHY, including an atlas of electrocardiograms. By Louis N. Katz, A.B., M.D. Illus. with 402 engravings, including 806 electrocardiograms. Pp. 580. Philadelphia, Lea & Febiger. 1941. \$10.00.

EXERCISES IN ELECTROCARDIOGRAPHIC INTERPRETATION. By Louis N. Katz, A.B., M.D. 128 engravings including 189 electrocardiograms. Pp. 222. Philadelphia, Lea & Febiger. \$5.00.

ABDOMINAL SURGERY OF INFANCY AND CHILDHOOD. By William E. Ladd, M.D., and Robert E. Gross, M.D. Pp. 455, illustrated. Philadelphia, W. B. Saunders Co.

BOOK REVIEWS

BONE GRAFT SURGERY IN DISEASE, INJURY AND DEFORMITY. By Fred H. Albee, M.D., assisted by Alexander Kushner. Pp. 403. New York, D. Appleton-Century Co. 1940. \$7.50.

This book is undoubtedly the last word in bone graft surgery. While the bibliography is copious, it is evident that the work is from the vast personal experience of its author.

The text is well written and easily assimilated by

the reader. The illustrations are clear, beautifully drawn and of great assistance. The entire volume exhibits the mechanical, surgical and creative genius of its writer.

The subject matter is most valuable to the surgeon, especially the orthopedic surgeon, who is familiar with the type of special surgery. It is of academic interest to the general practitioner.

J. IRVING FORT, M.D.

Books listed or reviewed in this Journal may be seen or consulted in the Library of the Academy of Medicine of Northern New Jersey at 91 Lincoln Park, Newark.

THE COMPLEAT PEDIATRICIAN. By Wilburt C. Davison, M.D. Durham, North Carolina. Duke University Press.

This compact pediatric *vade mecum* is surely unique in the field of medical journalism. It is an ingenious compilation of signs, symptoms, tests, diseases and treatment procedures, elaborately cross-referenced so that, after a little practice, the reader can swiftly find what he wants and learn what he must know without waste of time, words or effort.

Practically all the symptoms and signs that come into the ken of the pediatrician are here. With each is a list of the diseases to which these symptoms might be clues; a symbol indicates whether the finding is common or rare in that disease. After each disease is a key number referring to a fuller consideration of the disorder. For example, if cyanosis is the presenting sign, the practitioner turns to the paragraph labelled "Cyanosis". Here he sees a list of disorders commonly accompanied by cyanosis—quinsy, asthma, foreign bodies, etc.; and a list of the diseases less often signalled by cyanosis. The reader then turns to each of these (easily found because of the attached paragraph numerals) and sees which present a symptomatic pattern most closely conforming to the actual case.

The next chapter lists some 300 distinct diseases, with a brief tabulation of the etiology, symptomatology, diagnosis and treatment of each. Treatment is given in concise, practical fashion. Doses are accurately given, methods of administration described. The cross-references enormously expand the usefulness of this. To take an example at random. Looking under "poison ivy", the reader sees the symptomatology and diagnosis; and under treatment, in addition to medication, is mention of desensitization and ultra-violet radiation. These are keyed to other paragraphs, in which the techniques of desensitization and radiation are detailed.

An interesting chapter on preventive methods in pediatrics is followed by a practical treatise on pediatric nursing which describes precisely techniques like making the infant's bed, bathing the baby, preparing croup tents, introducing enemas, etc.

Naturally infant feeding is exhaustively treated, with tables of diets, recipes and menus. In fact, the reader can learn how to make a palatable mayonnaise from one of Davison's recipes. An especially useful chapter on drugs and prescriptions gives exact doses and describes methods of administration. By following the author's instructions, the reader can prepare an ointment for eczema, a standard gargle, or a spray for bed bugs with equal facility. A useful section on laboratory methods gives staining techniques as well as the usual material on blood, sputum, feces, and urine analysis. The volume closes with suggested forms for taking histories and recording physical findings. A final paragraph lists the proper contents for a pediatrician's bag. This admirable list suffers from only one omission. Surely among the items in every pediatrician's bag should be this little book itself.

METHODS OF TREATMENT. By Logan Clendening, M.D., and Edward H. Hashinger, A.B., M.D. With chapters on special subjects by J. B. Cowherd et al. 7th ed. Pp. 997. St. Louis, C. V. Mosby Company. 1941. \$10.00.

The senior author, his co-author and a number of other writers in special fields have sought to describe all methods used in modern medical treatment. There are comprehensive chapters on rest, drugs, immunologic products, anesthetics, hormones, dietetics, infant feeding and physical therapy. Special procedures such as blood transfusions, spinal and cisternal punctures, thoracentesis, paracentesis, resuscitations, and artificial respiration are described.

Chapters on radiotherapy and psychotherapy are helpful to the practitioner, though not intended as exhaustive treatises on the subjects. Climate, aero-therapy, and health resorts are discussed with much the same purpose.

In part II, methods of treatment used in the several classes of diseases are discussed. The commonest methods receive the most space and the authors are free in stating their own opinions. There is a good presentation of the usefulness of sulfanilamide and sulfathiazole. Some other new drugs are also described, but no mention is made of snake venom solutions. On the whole, the book not only constitutes a good practical reference, but also merits a thorough cover-to-cover reading.

PAUL E. REPASS, M.D., East Orange.

GETTING READY TO BE A MOTHER. By Carolyn Conant Van Blarcom, revised by Hazel Corbin. 4th ed. Pp. 190. New York, The Macmillan Company. 1940. \$2.50.

This little volume will be of great value to those facing motherhood for the first time. It gives just the kind of information in which lay people are interested, scientific enough to give real information but with the right kind of diction and illustrations to make the book understandable to the laity. It should save the busy obstetrician much time in repetitious explanations.

M. N.

AN INTRODUCTION TO DERMATOLOGY. By Richard L. Sutton, M.D., and Richard L. Sutton, Jr., M.D. With 723 illustrations. 4th ed. Pp. 904. St. Louis, C. V. Mosby Co. 1941. \$9.00.

For the general practitioner who wishes a book on dermatology, this fourth edition by the Suttons is outstanding. The arrangement of the diagnosis and classification is the most satisfactory the reviewer has seen. It is an up-to-the-minute volume. Many of the long, mysterious-sounding synonyms for which our specialty is noted have been eliminated. The illustrations are exceptionally good. For the busy dermatologist, all the latest investigative data is briefly and concisely enumerated with a wealth of information in as few words as possible.

FRANCIS J. MCCAULEY, M.D.

THERAPY OF THE NEUROSES AND PSYCHONEUROSES. By Samuel Henry Kraines, M.D. Pp. 512. Philadelphia, Lea & Febiger. 1941. \$5.50.

According to the author, "This book has been written to state not only some of the facts about man and the malady of his actions but to offer an interpretation of, and a practical technique for meeting some of his problems. This book is an attempt at an orientation, an orientation which studies man as he is, in the social, psychologic and biological setting in which he is conceived and matured."

The author is enthusiastic, ambitious and desirous of being as helpful as possible in his presentation of cases and in his suggestions for treatment.

It is not a book for the neuropsychiatric specialist. It should appeal to the general practitioner and specialists in other fields. No doubt it will be helpful to these physicians.

Adolph Meyer in his foreword says that "the author presents what he would like physicians to share with him. He has written a compend, personal but shareable, ringing true to both fellow worker and patient."

It should serve the purpose for which it was written.

CHRISTOPHER C. BELING, M.D.

PHYSICAL MEDICINE; the employment of physical agents for diagnosis and therapy. By Frank H. Krusen, M.D. Pp. 846, with 351 illustrations. Philadelphia, W. B. Saunders Co. 1941. \$10.00.

The author follows an orderly system and presents each physical agent under eight headings, viz.:—Introduction, Physics, Source, Physiologic Effects, Technic of Application, Indications, Contraindications and Conclusion. The book is extremely well illustrated and contains numerous references of great value to those students who wish to follow up any subject in detail.

A well-balanced book on physical medicine has been needed for a long time. Many have been written on isolated phases of the subject, tending to an overemphasis, and identifying physical medicine with just one or two physical agents. Dr. Krusen's

book covers the whole field. It is especially gratifying to see that more than 150 pages are devoted to mechanotherapy, including massage, exercises, rest and relaxation, and mechanical devices. These are, in the reviewer's opinion, still the most important agents of physical medicine. The sections on clinical aspects of physical medicine should prove to be of great value to specialist and practitioner alike. Two chapters are devoted to physical therapy in arthritis and backache, conditions seen almost daily, and in the management of which physical therapy is indispensable.

Physical Medicine is an outstanding book and should be valuable to all medical men.

B. S. TROEDSSON, M.D.

SYNOPSIS OF DISEASES OF THE HEART AND ARTERIES.

By George R. Herrmann, M.D. 2d ed. Pp. 468. St. Louis, C. V. Mosby Company. 1941. \$5.00.

The second edition of Dr. Herrmann's work is longer than the first, but it is no improvement. The author has many illustrations in the book, but these are mostly so diagrammatic or poor, that in many instances they are likely to prove confusing rather than helpful. Moreover, some of these, such as that of a Baumanometer, certainly take up room that could be used to greater advantage by enlarging on some portions of the text. There are, unfortunately, gross errors in some of the electrocardiographic illustrations that cannot help but be upsetting to the inexperienced for whom professedly this "outline" of 468 pages was written.

The author has added a chapter on "Military Cardiovascular Examinations and Interpretations", which is of some value, since it does follow some of the criteria advocated by the service. However, the author has also included many of his own ideas which may or may not be acceptable.

In all, I may say, that Dr. Herrmann has tried to say a little about many things and has therefore succeeded only in confusing rather than helping the doctor or student looking for specific information. In an epidemic of cardiologic publications it is just another book.

A. E. PARSONNET, M.D., Newark.



ON THE FACE OF IT, THE PROBLEM OF DISTRIBUTING medical care is absurdly simple. So many people need the care; here are so many doctors with spare time and empty waiting rooms. Why not have the government bring them together? Simple, isn't it? And the economists, from whose fertile brains such schemes are being born, seem annoyed at the "stubbornness" of doctors who won't swallow their plans. But consider: here are wheat fields heavy with grain, and here are families hungry for bread. How about having the government bring them together? "Oh no," retorts the economist, "that's socialism; that's confiscation; that's a destruction of the stimulus to profit."

The economist obviously hasn't solved the problem of distributing food or shelter. Having demonstrated an inability to solve their own problem, therefore, they are bewildered when medical experts show no enthusiasm for letting them "solve" the problems of others. To put it another way. When all who want to, can find work at a decent wage, there will be no medical-care economic problem, since everyone will be able to select and compensate his own doctor. And when will everyone find work at a decent wage? When these "economists" learn how to make their own business function. These would-be managers of medicine can't expect much of a welcome until they give more visible evidence of their managerial skill.

● THE BULLETIN BOARD ●

Dr. Clarence W. Way, long an active and leading member of the Cape May County Medical Society and of The Medical Society of New Jersey, has been called to active duty by the U. S. Army as a Major in the Medical Corps. Dr. Way, Editor of The Journal of The Medical Society of Cape May County, is a member of the House of Delegates of The Medical Society of New Jersey. He was Cape May's representative on our Nominating Committee and is an Alternate Delegate to the American Medical Association. Dr. Way reported for active duty on July 15.

Members of the Medical Society may soon receive a visit from Mr. Joseph Merante, who has taken photographs of all the Trustees, Officers and Fellows, and who is engaged at present in securing photographs of the members of the Society for the files of the Executive Office. The Executive Office is anxious to secure a file of photographs of all members, so that these may be available for making cuts and slides when needed in the Society's activities. There will be no charge to the physician for the single photograph taken for the Society's files, nor will there be any obligation to purchase photographs for personal use from Mr. Merante.

Doctors interested in physiology and dietetics will want to attend a symposium on enzymes and the vitamins, which has been arranged by the University of Wisconsin and will be held on the campus at Madison from September 11 to September 13. The conference will then be continued by the University of Chicago on its campus from September 15 to September 17.

On the theory that substitution is better than repression, the Parents' Institute is setting up a series of wholesome but exciting "comics", to attract the interest of the children of the country who last year bought 15,000,000 copies of lurid, fantastic, unappetizing "comics". These comics have been characterized "a poisonous mushroom growth of sex-horror serials, badly drawn, badly written and badly printed, destructive of a child's natural sense of color". To compete with this the Parents' Institute has prepared a series of magazines which resemble the format of other "comic" magazines, but which deal with exciting adventures of historical characters. Pediatricians, psychiatrists and all physicians who have personal and professional interest in children may secure advance proofs of "True Comics" from the Parents' Institute, 52 Vanderbilt Avenue, New York City.

Hypertension and other cardiovascular diseases will be the theme of the Graduate Fortnight of the New York Academy of Medicine, which will be held

October 13-24, 1941. The project includes discussions, clinics, demonstrations, speeches and exhibits. A complete program may be secured by addressing Dr. Mahlon Ashford, New York Academy of Medicine, 2 East 103rd Street, New York City.

Obstetricians and gynecologists are reminded that applications for the next examination of the American Board of Obstetrics and Gynecology must be on file with Dr. Titus by October 6, 1941. The written examinations will be held on January 3, 1942. For information, address: Dr. Paul Titus, 1015 Highland Building, Pittsburgh, Pennsylvania.

A member of The Medical Society of New Jersey is now Acting President of the Woman's Medical College of Pennsylvania. She is Dr. Ellen C. Potter, Director of the Division of Medicine in the New Jersey Department of Institutions and Agencies, and a member of our Mercer County Medical Society.

The National Society for the Prevention of Blindness will meet in New York City December 4, 5 and 6. For further information interested physicians may write to the Society at 1790 Broadway, New York.

The American College of Surgeons will hold its Clinical Conference in Boston, November 3 to 7, concurrently with the annual Hospital Standardization Conference, sponsored by the American College of Surgeons. Details of the meeting may be secured by writing to Dr. B. C. Crowell, American College of Surgeons, 40 East Erie Street, Chicago.

The Connecticut State Medical Society will hold its seventeenth annual Clinical Congress at Yale University in New Haven, on Tuesday, Wednesday and Thursday, September 16, 17, and 18. Among the guest speakers will be Drs. Frank H. Lahey, Emil Novak, Ernest P. Boas and Burrill B. Crohn. Tuesday morning's session will be devoted chiefly to gynecology, Tuesday afternoon's to the effects of trauma, and Wednesday morning's to cardiovascular disease. The remaining sessions will present a well-rounded program of interest to all physicians, especially general practitioners. Guest-physicians may enroll in a special course in traumatic surgery, under the direction of Dr. Samuel C. Harvey of the Yale School of Medicine. This will begin September 16. Any physician may attend the Congress. Registration fee is \$2.00. The special course in traumatic surgery is \$1.00 additional. Detailed information and registration cards may be obtained from The Connecticut Clinical Congress, 258 Church Street, New Haven, Connecticut.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XIV

August, 1941

No. 8

FINDINGS in an extensive tuberculosis survey in Chicago schools, using the tuberculin test as a screen, are now available. While it is not a new conclusion that routine skin testing in elementary school groups is not an economical procedure, the report does contribute materially to our knowledge of the epidemiology of tuberculosis and permits comparison with previous surveys in the same city.

TUBERCULIN TESTING IN CHICAGO SCHOOLS

This survey was carried out by the Chicago Municipal Sanitarium, aided by the Tuberculosis Institute of Chicago and Cook County.

The survey policy of the Municipal Tuberculosis Sanitarium had hitherto been largely oriented toward older groups. Tuberculin testing in the schools, therefore, represented a deviation from established policy and was undertaken in order to explore educational values, morbidity rates, and case-finding potentialities of a follow-up of the reactors and to check on existent case-finding machinery.

As the purpose was to obtain a cross-section of tuberculosis morbidity, the survey—attempted to include every Chicago school. However, it was necessary to sacrifice certain ambitions, such as a 100% consent and a thorough survey of each school. In a general way, the policy ran, "Get what consents you can in the time allotted and go on to the next school."

Kindergarten, first and eighth grade children and all available students in the high schools were examined because a positive reaction in a kindergarten or first grade child might have some epidemiological significance; eighth grade children were on the threshold of adolescence and many would not go to high school. Thus it might be their last chance of inclusion in a case-finding effort. In view of the many studies already made, justifiability of high school examination was hardly debatable.

First, the Board of Education notified the principals. Then the nurse addressed the teachers and children in each room. All were given appropriate literature which, with the consent card, the children took home. After due interval the

operating team did the tuberculin test and results were read in forty-eight hours.

In all, 176,878 consents were obtained in 561 public elementary schools, 115 public high schools, 347 parochial elementary schools, 47 parochial high schools, 12 trade and vocational schools and 5 junior colleges.

A self-contained and complete mobile unit, the first as far as is known to be used in the X-ray field, was devised. On starting work the truck drove into the school yard and the technician selected a location as near as possible to space for extra dressing rooms. Current was obtained through a cable from a school connection.

The procedure, carefully standardized, was to give a single Mantoux test using Purified Protein Derivative in an amount one-tenth the usual final dose. The percentage of reactors with this dose was low compared with the experience in other urban areas so the injection unit was doubled in the latter part of the work, except in the case of Negroes and Mexicans who had shown marked sensitivity to tuberculin.

In the 167,345 children tested, 27,401 proved positive. To March 1, 1940, 23,532 had been X-rayed and 218 cases of reinfection type tuberculosis were found of whom 109, or 50%, were in the moderately or far advanced stage; in 4,524 children, evidence of primary infection type tuberculosis was found.

The reactor rate and the primary tuberculosis rate was practically the same for boys and girls but the incidence of reinfection type tuberculosis was twice as high in girls. The incidence of disease among children X-rayed was higher in Negroes and Mexicans but not to the same degree

as the infection rate. The Negro children had slightly less primary tuberculosis than the white.

The study seemed to bear out the reports of other workers who found a lack of constant correlation between tuberculin sensitivity and tuberculous calcifications.

In comparison with other metropolitan surveys, the reaction incidence in Chicago is low. This may be due to the fact that no open case may live in the same home with children under sixteen. Contact is broken as soon as possible after discovery of the case.

Survey results confined to a district or a constellation of districts would lead to false conclusions. The survey included schools in every district and children from every economic level. The major part of the tuberculosis problem is sharply localized. About four of the 75 census districts account for 38% of the deaths. Mortality in these areas is much higher than the general rate, namely, 196 per 100,000 as compared to 51.6 per 100,000 for the city as a whole. Morbidity figures run low in the same ratio.

In Chicago, as elsewhere, decreasing mortality rates probably exerted influence on the composition of the infection index. The rate has fallen from 147.9 per 100,000 in 1917 to 51.6 per 100,000 in 1939. Over the same period, the rate has fallen from 133.9 to 34.0 for whites and from 414.0 to 281.7 for Negroes, per 100,000.

In an attempt to estimate the diminution of the reactor rate the present figures may be compared to older studies, one made by Webb of the University of Chicago in 1930-31, the other by Novak and Kruglick of the Tuberculosis Institute of Chicago and Cook County in 1933-37. Webb tested no high school children and Novak and Kruglick tested no elementary school children. In elementary school ages, comparing Webb's figures with the present study, since 1930-31 there has been a definite drop for each age period. Comparing high school tests for 1933-37 and 1936-39, there is also a substantial drop for each age period, except for age twenty; only 29 students of this age were tested in the Novak study.

The specific relation between tuberculin positives and tuberculosis in the home was clearly demonstrated in the present survey. The source of infection was unmistakably established in 3,284 instances but of these only 226 were new pulmonary cases.

The comparatively small number of new cases

found in the families of the positive reactors was both a disappointment and a satisfaction. A larger proportion of new tuberculosis had been anticipated but it was encouraging to know that the existent case-finding machinery was effective, since in 90% of the cases the source of infection was already under supervision.

Altogether, 586 new cases of tuberculosis were found. The total cost chargeable to the survey for the 586 cases found was \$511.95 per case.

In order to explore its potentialities, figuratively speaking, the miniature X-ray was carried almost to the doorstep of the people in the congested areas. The equipment was hooked up to the mobile X-ray truck and this self-contained unit, including dressing rooms, was taken to various locations.

The plan, still operative, aims to make an X-ray examination of every man, woman and child in certain areas of gross congestion, high tuberculosis mortality and low economic status.

In the school survey, lasting three years and comprising 23,532 X-ray examinations, 218 new cases were found on the first film. In the miniature X-ray survey comprising 20,956 examinations and lasting five months, 675 new cases were found by the original X-ray.

Summary

During the three-year period, 167,345 children were tuberculin tested and 23,532 X-rayed. The reactor incidence was 7.04% for kindergarten and first grade, 19.82% for eighth grade, 21.29% for high school students and 29.97% for miscellaneous schools and colleges. The rate for Negroes was twice that of whites and for Mexicans it was still higher.

This study shows a substantial drop in the reactor rate in Chicago as compared with older studies. The city-wide survey emphasized the fact that each district had its own reactor rate which was allied to local mortality rates.

Of 57,481 children under twelve tested with tuberculin, 9 cases of pulmonary disease were found, which is comparable to figures for this age group in the mortality tables. Facts point toward the adolescent and early adult years as the case-finding provinces. In testing adults in highly infected milieus (60% reactions or more) X-ray of the entire group is cheaper than tuberculin testing with X-ray of the positives.

Bulletin, Chicago Municipal Sanitarium, Vols. 18-19-20, Years 1938-39-40, 1-12, inc.

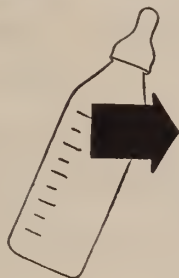
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1. Knight, F., and Shelanski, H. A., "Treatment of Acute Anterior Urethritis with Silver Picrate," *Am. J. Syph., Gon. & Ven. Dis.*, 23, 201 (March), 1939.

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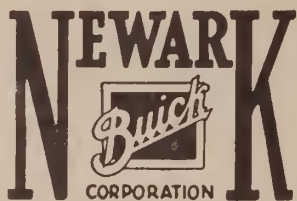
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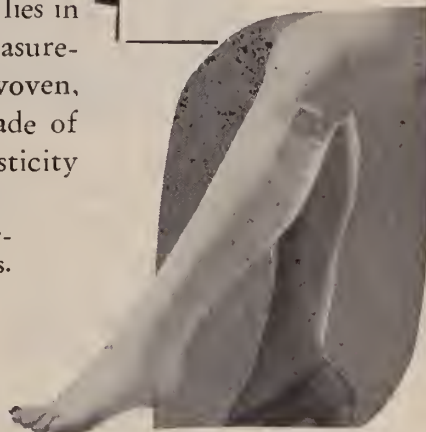
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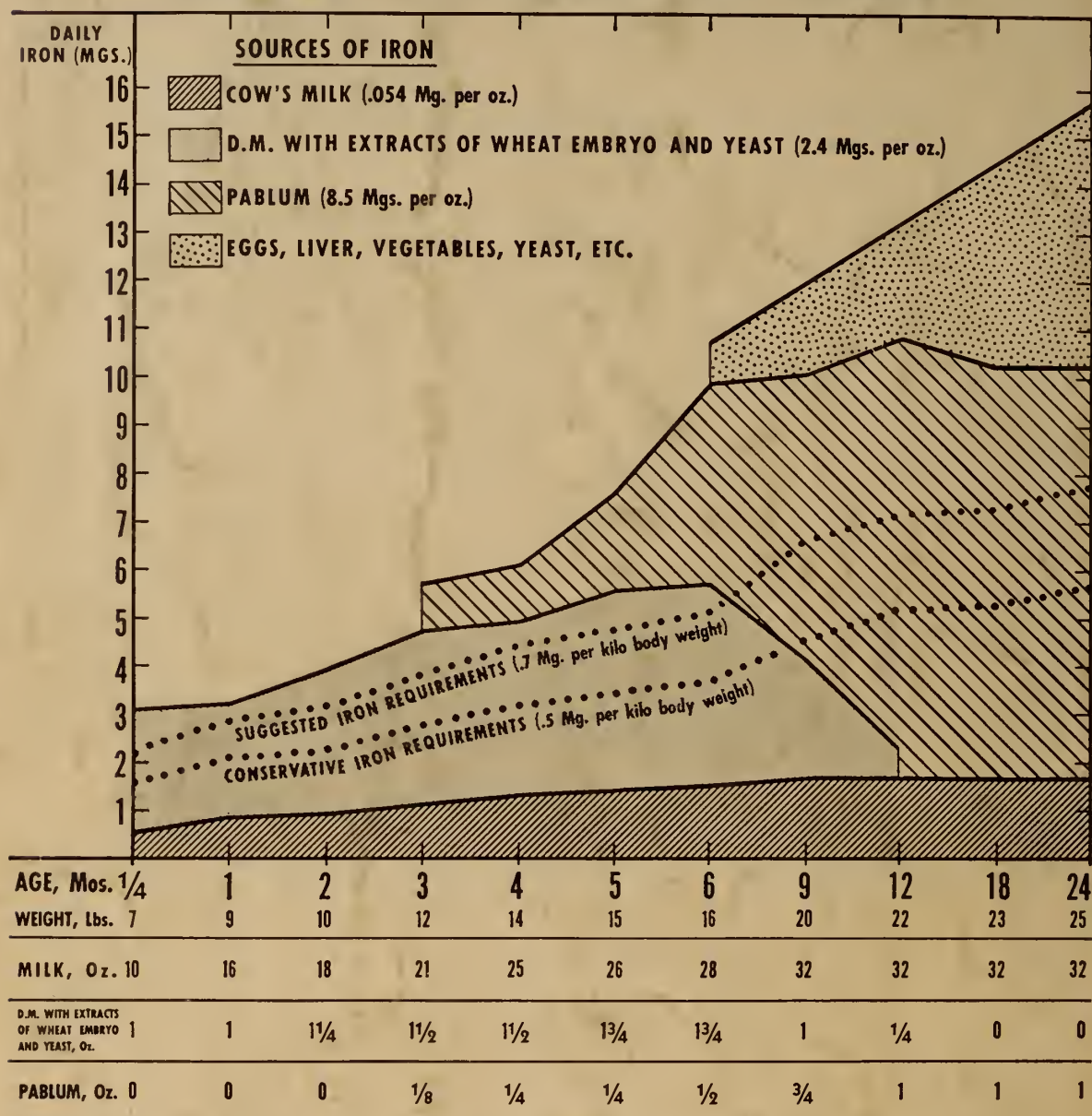
Consider the routine use of the Petrolagar cleansing enema in the hospital, postoperatively or in obstetrical cases, where normal bowel habits are temporarily disturbed.

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IRON REQUIREMENTS DURING THE FIRST TWO YEARS



During fetal life the infant accumulates iron in its body. After birth, this supply is rapidly depleted, the hemoglobin frequently dropping to 50% by the third month, especially in prematures. Neither breast milk nor cow's milk is capable of offsetting this loss, as they are deficient in iron. An infant requires one-half milligram of iron per kilogram of body weight. This chart shows that when the carbohydrate and cereal supplements contain iron, a sizeable margin of safety can be maintained,

not only during the important first six months, but throughout the first two years of life.

The excess iron thus supplied over iron requirements averages close to 75%, and is needed because some iron is unutilized—a large amount in certain cases. In rapidly growing, or poorly nourished infants, and in the presence of infection, the need for iron may be greater than the chart shows; in some cases, periodic hemoglobin determinations may show the need for iron therapy.

THE 175th ANNUAL MEETING OF THE MEDICAL SOCIETY OF NEW JERSEY

Haddon Hall, Atlantic City, May 20-21-22, 1941

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THE OFFICIAL TRANSACTIONS

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The One Hundred and Sixty-fifth Legislature of the State of New Jersey

ASSEMBLY CHAMBER
STATE HOUSE, TRENTON, N. J.

ASSEMBLY CONCURRENT RESOLUTION

By Mr. Hargrave, of Essex County
Introduced and Adopted by the House of Assembly May 19, 1941, and
Concurred in by the Senate May 19, 1941

WHEREAS, The Medical Society of New Jersey, the oldest medical society in the United States, having been founded ten years before the independence of our country, is celebrating in annual convention at Atlantic City, May 20th to the 22nd, the 175th anniversary of its organization; and

WHEREAS, The Medical Society of New Jersey and its members have rendered over this long period of years signal service to the public welfare of this State; therefore

Be It Resolved, That the House of Assembly of the New Jersey State Legislature (the Senate concurring), extends to the Medical Society of New Jersey its congratulations upon its 175th anniversary and its best wishes for the continued success and service of this organization; and

Be It Further Resolved, That a copy of this resolution, signed by the President of the Senate and the Speaker of the House, and attested by the Secretary of the Senate and the Clerk of the House, respectively, be forwarded to Doctor Watson B. Morris, President of the Medical Society of New Jersey, at Haddon Hall, Atlantic City, New Jersey.

Rose P. McCleave
Speaker of the House of Assembly.

Attest:

Paul Williams
Clerk of the House of Assembly.

Frank B. Rowland
President of the Senate.

Attest:

John H. ...
Secretary of the Senate.

I hereby certify that this is a true and official copy of a resolution introduced and adopted on Monday, May 19, 1941.

Paul Williams
Clerk of the House of Assembly.

THE MINUTES OF THE HOUSE OF DELEGATES

Session 1. Tuesday Morning, May 20, 1941

Assembled in its 175th Annual Meeting, the first session of the House of Delegates of The Medical Society of New Jersey convened in Haddon Hall, Atlantic City, at ten:forty o'clock in the forenoon, the President, Dr. Watson B. Morris, presiding.

PRESIDENT MORRIS: I now declare the 175th meeting of The Medical Society of New Jersey in session.

Prayer was offered by Reverend George W. Lawrence of Ventnor. Dr. Samuel L. Salasin welcomed the Delegates and Members in the name of the Mayor and the City of Atlantic City. Dr. Harry Subin, President of the Atlantic County Medical Society, delivered the greetings of the host county.

President Morris called on the assemblage to rise and observe a moment of reverent silence in memory of our departed brethren.

On motion, the minutes of the last meeting, as published in the *Journal*, were accepted as printed. Roll call showed the presence of a quorum.

RESOLUTION

PRESIDENT MORRIS: Reports of Officers and Trustees as well as of all the committees were printed in the *Journal*. Copies were sent to all Delegates. If there are supplementary reports to be made, I wish they would be presented at this time. Copies will be sent to the Reference Committees.

DR. THOMAS B. LEE (Camden County): I have a resolution to present that was approved by the Board of Trustees last night. This is presented on behalf of the women physicians who wish, where and when they can, to participate in the preparedness program of the country. This resolution has been passed by the New York State Medical Society unanimously, by the New York County Medical Society and by the Academy of Medicine of New York City; maybe some others, but those we know about.

Whereas, The United States of America is at present engaged in a vast Preparedness Program which includes a listing of members of the Medical Reserve Corps available for active service, and

Whereas, There are approximately 8,000 women physicians and surgeons in the United States who form only a small minority group in the 175,000 registered physicians, and

Whereas, The United States Government has to date taken no cognizance of these women physicians in time of war except to appoint them as Contract Surgeons in a few isolated cases—and the status of the Contract Surgeon is definitely inferior

to the status of the physician in the Medical Reserve Corps on three counts:

First: There is no military ranking, hence curtailment of authority and necessity of trying to do work under anomalous conditions;

Second: Inferior salaries;

Third: No wartime insurance or pensions; and

Whereas, The women physicians and surgeons of America demonstrated their fitness for wartime service during the first World War when they raised funds, financed units, and staffed hospitals with well-trained officers in France and Serbia and did heroic work in the devastated areas, and thereby proved that sex does not count in times of national disaster and medical emergency, but that ability and skill do; and

Whereas, Women physicians, as was demonstrated in the first World War, may well be of great service not on duty with troops but in Army and Navy Base and Reconstruction Hospitals where their assignment will release male Medical Officers for active duty with the fighting forces; and

Whereas, The Government has already granted women nurses Army rating with proper rank, pay, and war risk insurance; and

Whereas, The members of the American Medical Women's Association are for the most part members of the American Medical Association, pay the regular dues and enjoy all the privileges of full membership; therefore

Be It Resolved, That The Medical Society of New Jersey recommend that there be created Women's Divisions of the Medical Reserve Corps of the United States Army and the United States Navy so that if and when women physicians are called to duty in Army or Navy Hospitals they shall have the authority, benefits and privileges belonging to Officers of the Army and Navy; and

Be It Further Resolved, That The Medical Society of New Jersey instruct their Delegates to the House of Delegates of the American Medical Association, that this business shall be laid before the House of Delegates of the American Medical Association for their favorable consideration at the Annual Meeting in Cleveland in June, 1941.

PRESIDENT MORRIS: This will be referred to the Committee on Resolutions and Memorials. Dr. Wendell Burkett is Chairman.

Action: See page 17.

BUSINESS ORGANIZATION COMMITTEE

DR. WILLIAM F. COSTELLO (Morris County): Mr. Chairman and Gentlemen: Since rendering our report in the *Journal* we have had two meetings. The data on those meetings will be in the *Journal*.

During the year we appointed a Business Organization Committee. The function of that committee has been to survey the activities of the Society through the Executive Office, the work of the committees as a whole, and to try to evaluate this work in relation to results that we feel have been obtained with the amount of money that has been spent.

That Committee on Business Organization has done a tremendous amount of work. I should just like to read the preliminary report of that committee, as submitted to us at the March meeting of the Board of Trustees.

(Abstract)

The Committee finds the office efficiently operated and cannot suggest any major specific improvement. Analytic studies have been made of organization, personnel, and costs. The Committee believes that there may be some lack of planning, in consideration of the amount of clerical work, correspondence and similar sources of expense on the part of some officers and committees. Certain committees have become so wrapped up in their work as to forget the extent of their demands on the office and their relation to the whole work of the Society. The House of Delegates and Board of Trustees too frequently authorize some project after the budget has been adopted, without provision for the expense. The Committee recommends:

1. That no committee undertake any project without assurance that funds are available, or without an allotment by the Finance Committee. If this is not done, the bills incurred cannot be paid.
2. All committees should be notified of this regulation.
3. Committees should be warned to plan their programs to accord with their budgets.
4. Administrative control should be established to determine priorities among projects and to decline or postpone work for which appropriations are not available. The control should rest in the first instance in the Executive Officer, subject to the approval of the President or the Trustees.
5. Officers, committeemen and county chairmen are reminded that a letter often serves as well as an expensive telephone call if it can be met by a prompt reply.

PRESIDENT MORRIS: That report will be referred to Committee "A". Dr. Allman is Chairman.

Action: See page 11.

SERVICE MEMBERS' DUES

DR. HARRY N. COMANDO (Essex County) read the following resolution:

Whereas, The National Emergency which now exists by proclamations of the President of the United States has called into the Military Service of the country many members of The Medical Society of New Jersey.

Whereas, It is the obligation and duty of The Medical Society of New Jersey to cooperate to the fullest extent and whereas the majority of those of our membership who have been called on active duty with the military forces are sacrificing many of their personal interests;

Therefore, Be It Resolved, That this House of Delegates in convention assembled, officially recognize these circumstances and direct the Board of Trustees to appropriate the sum of two thousand dollars (\$2,000.) from such funds as are now in the reserve of The Medical Society of New Jersey, to pay for the individual assessment of such members of The Medical Society of New Jersey who are on active duty either with the United States Army or the United States Navy during the duration of the emergency.

This maintenance of membership in good standing shall be in the form of recompense to the component Societies by the return of such per capita assessments as may be advanced by them to the State Society.

PRESIDENT MORRIS: That will be referred to the Committee on Resolutions and Memorials.

Action: See pages 17 and 18.

FOREIGN GRADUATES

DR. FREDERIC J. QUIGLEY (Hudson County): Mr. President: The Legislature is still in session so the Sub-Committee on Legislation is unable to render a complete report, but one bill has passed since the formal report was rendered, of which the committee feels the Delegates should be advised.

There are one or two graduates of Italian schools, citizens of this country and residents of New Jersey, who because of Italy's entrance into the war, were compelled, upon the advice of the consuls, to leave before they received their licenses to practice.

In the matter of foreign graduates, the Medical Practice Act demands that in addition to their having a diploma they be licensed in the country in which they studied.

The Committee was very reluctant to recommend to the Welfare Committee any change in the Medical Practice Act, but in April, subsequent to our last meeting of the Legislative Committee, we advised that the Board of Medical Examiners felt that an emergency change should be made to take care of the situation.

Some seven residents of New Jersey are graduates of Italian schools, and even though they are American citizens, if they are sons of Italians and are in Italy at the time of an emergency, they may be inducted into the military service of Italy. So the Board of Medical Examiners recommended an amendment to the act.

This amendment has been passed and has been signed by the Governor.

ASSEMBLY, NO. 469

Amending Section 45:9-8 of the Revised Statutes.
Line 11—medicine and surgery in some foreign country, or if the said foreign country is engaged in war at any time during the next three years and the said applicant before June thirtieth, one

thousand nine hundred and forty-four, satisfactorily proves to the board that he has been a resident of the State of New Jersey for the past ten years, he shall present a diploma from a professional school or college which in the opinion of the board was in good standing at the time of the issuance of the diploma.

INTERN CERTIFICATE FEE

One other amendment to the act was incorporated in this same bill. Until the present, interns were required to pay ten dollars for a certificate before they could start their internship. The New Jersey Hospital Association felt that this worked a hardship on some of the young men and made it difficult for hospitals to obtain interns. Inasmuch as the defense effort may make it increasingly difficult to get interns, it was felt that that fee should be vacated. An amendment was made to this bill, whereby interns applying for certificates no longer have to pay that fee of ten dollars.

Incidentally, this means a decrease in the Board's revenue of about two thousand dollars a year.

The Committee would like to acknowledge, first, the splendid coöperation of the medical men in the Legislature. Dr. Hargrave, of Essex, Chairman of the Public Health Committee, and Dr. Wegrocki have been most helpful, and the fact that they are keymen on this committee makes a great deal of difference in the sympathetic handling of bills referred to it.

In the Senate, we have been very fortunate in that as a successor to our very warm friend, Senator Taggart, now Mayor of Atlantic City, Senator Summerill, of Salem County, is now Chairman of the Committee on Public Health. His father was a doctor and he has a brother a doctor, and his attitude towards public health measures is the same as ours. In the Senate, no bill can be reported out unless the chairman of that committee is willing to report it out.

In the Senate also, the President, Senator Scott, has been very coöperative; and in the Assembly, mention should be made of the very fine and sympathetic attitude that has been continuously displayed by the Speaker, Mr. Roscoe P. McClave, who, as you know, sponsored our Uniform Medical Practice Act. (Applause.)

PRESIDENT MORRIS: Thank you, Doctor!

That will be referred to Committee "F".

Action: See page 13.

Dr. Charles H. Schlichter, of Union County, presented the Supplementary Report of the Medical Preparedness Committee.

PRESIDENT MORRIS: That report will be referred to Committee "D".

Action: See page 12.

STANDARDS FOR PSYCHIATRISTS

DR. REEVE L. BALLINGER (Hudson County): I have a resolution that was passed at the last meeting of the Hudson County Medical Society.

Whereas, The New Jersey State Department of Public Instruction is reported to be considering establishing a standard for qualifications of psychiatrists and psychologists who may be appointed to positions in the Public School System throughout the State, and

Whereas, The Director of the Bureau of Teachers' Qualifications, which would handle these matters, has been reported to have taken the stand that, "It is doubtful that there would be any distinction between the general requirements for psychiatrists and psychologists, if the psychologist is equipped to perform the duties and responsibilities of a psychiatrist"; and

Whereas, The Director of the Bureau of Teachers Qualifications does not recognize any distinction between psychiatrists and psychologists and indicates a belief that a psychologist can perform the duties and functions of a psychiatrist; and

Whereas, It is reported that a committee of school psychologists are working on this matter; and

Whereas, The public is already confused regarding the distinction between these two professions; and

Whereas, Such action by the State Department of Public Instruction would increase this confusion and would further open up the opportunities of unqualified persons to perform the functions of a psychiatrist and practice psychiatry; and

Whereas, The basic distinction between a psychiatrist and psychologist, which is not generally understood, is that a psychiatrist must be a Doctor of Medicine duly licensed to practice medicine in the State and that the removal of this distinction by the State Department of Public Instruction would not be in accord with the facts in the law;

Therefore, Be It Resolved, That The Medical Society of New Jersey believes that it is imperative that a distinction be made between the qualifications of a psychologist and the qualifications of a psychiatrist, and that it further believes that the minimum qualifications of a psychiatrist for employment in the Public School System should not be less than now required by statute to qualify for the certification for the admission of a person to an institution in this State established for the care of the insane, epileptic and feeble-minded; and

Be It Further Resolved, That this Society take all proper steps to protest to the Department of Public Instruction of this State against any action by them that would not retain the proper distinction between these two groups; and

Be It Further Resolved, That the Officers of The Medical Society of New Jersey, and the proper committees thereof be instructed to take such actions as may be necessary to bring the views of this Society to the attention of the State Department of Public Instruction, and such other agencies as may be deemed necessary.

PRESIDENT MORRIS: Thank you, Doctor!

This will be referred to the Committee on Resolutions and Memorials.

Action: See pages 18 and 19.

TREASURER'S REPORT

DR. GEORGE J. YOUNG (Morris County): The report of the Treasurer has been mimeographed and has been placed in your hands.

Dr. Young then read the report:

PERMANENT CAPITAL FUND

	May 13, 1940	May 13, 1941
4M U. S. Treasury Bonds . . .	\$ 4,045.94	\$ 4,045.94
Investors Mortgage & Realty Co.	1,921.75	1,836.25
Trenton Mortgage Service Co. . .	1,333.52	1,212.77
First National Bank of Paterson savings account . . .	7,764.04	349.54
Cash on hand		120.75
Cash on hand to purchase 7 \$1,000 and 1 \$500 Government Defense Bonds . . .		7,500.00
Total	\$15,065.25	\$15,065.25

KIPP MEMORIAL FUND

Eye, Ear and Throat Section

	May 13, 1940	May 13, 1941
Balance May 13, 1941, Howard Savings Institution	\$37.10	\$37.10

STATEMENT OF RECEIPTS AND DISBURSEMENTS

GENERAL FUNDS

June 1, 1940, to May 13, 1941

RECEIPTS

Cash Balance June 1, 1940	\$ 60,600.48
-------------------------------------	--------------

Assessments—

Atlantic	\$ 2,081.00
Bergen	4,326.00
Burlington	1,028.00
Camden	3,201.00
Cape May	400.00
Cumberland	992.00
Essex	17,619.50
Gloucester	816.00
Hudson	7,443.00
Hunterdon	532.00
Mercer	3,922.00
Middlesex	2,868.00
Monmouth	2,277.25
Morris	1,894.25
Ocean	464.00
Passaic	5,938.00
Salem	432.00
Somerset	1,026.00
Sussex	432.00
Union	5,520.00
Warren	449.00
Total	64,261.00
Interest	232.63

Publication, The Journal	\$11,549.29
Coöperative rebates	690.21
Commercial Exhibits, 1941	12,239.50
Revenue Not Anticipated	5,252.07
Unemployment Compensation taxes collected from employees (net)	47.71
Transferred from Executive Offices account	22.91
	17.00

Total \$142,673.30

STATEMENT OF RECEIPTS AND DISBURSEMENTS

GENERAL FUNDS

June 1, 1940, to May 13, 1941

DISBURSEMENTS

Administration

A- 1 Executive Salaries	\$ 7,583.32
A- 2 Salaries and Wages	4,825.00
A- 3 Office Expense (net)	1,679.11
A- 4 Traveling Expenses	798.39
A- 5 Rent	2,701.20
A- 6 Treasurer's Expenses	98.51
A- 7 Finance Committee	42.74
A- 8 Bonding	89.00
A- 9 Auditing	347.00
A-10 Secretary's Expenses	2,675.37
A-11a Unemployment Compensation	434.44
A-12 Insurance (net)	286.21
	\$ 21,560.29

Journal

B-1 Publication	\$11,898.99
B-2 Cuts	242.45
B-3 Editor's Salary	5,041.66
B-4 Salaries and Wages	1,434.56
B-5 Office Expenses	623.69
B-6 Traveling Expenses	106.25
B-7 Medical History	32.00
	19,379.60

Welfare Committee

C-1 General Welfare	\$ 307.43
C-2 Welfare Committee	206.44
C-3 Legislative Committee	3,336.43
C-4 Public Health	1,236.55
C-5 Public Relations	1,266.29
C-6 Medical Practice (net)	402.21
	6,755.35

Special Activities

D- 1 President's Fund	\$ 1,046.96
D- 3 Dues—Professional and Allied Conferences	25.00
D- 6 Fall Clinical Conference	719.42
D- 7 Conference of State and County Officers	48.00
D- 8 Woman's Auxiliary	407.16
D-11 Medical Service Plan (net)	5,630.82
D-12 Medical Preparedness Committee	1,334.52
	9,211.88
E—Contingent	653.64

Annual Meeting

G-1 Annual Meeting Committee	\$ 162.83
G-2 Scientific Sessions	47.82
G-4 Woman's Auxiliary	104.55
G-5 Scientific Exhibits	309.71
	624.91

H—Pension	1,375.00
Accounts Payable—year ended May 31, 1940	3,987.47
Advances to Medical Service Administration	4,000.00
Expenditures against reserves provided May 31, 1940—Medical Service Administration	5,000.00
	<hr/>
	\$ 72,548.14
Cash Balance May 13, 1941	70,125.16
	<hr/>
Total	\$142,673.30

COMPUTATION OF ESTIMATED CASH

SURPLUS

as at May 31, 1941

Before Audit and Subject to Revision

Cash—May 13, 1941	
Executive Offices	\$ 1,635.44
General Account	70,125.16
Publication Committee	999.19
	<hr/>
	\$72,759.79
Estimated Receipts from May 13 to May 31, 1941—	
Commercial Exhibit	\$ 140.00
Publication	500.00
	<hr/>
	640.00
	<hr/>
	\$73,399.79
Deduct—	
Assessments applicable to succeeding year 7/12 of \$62,224.00	\$36,297.35
Accounts payable—estimated—	
Budget	11,400.00
Annual Meeting	3,400.00
Commercial Exhibits	520.00
Balance due Medical Service Administration	2,000.00
	<hr/>
	53,617.35
Estimated Cash Surplus	\$19,782.44
Cash desired in surplus account	20,000.00
	<hr/>
Estimated deficit in surplus	\$ 217.56

See page 24 for Supplementary Report.

PRESIDENT MORRIS: This report will be referred to Reference Committee "C".

Action: See page 12.

Now we shall have the Report of the Finance and Budget Committee, of which Dr. North is Chairman.

DR. HARRY R. NORTH (Mercer County): You have all heard the report of the Chairman of the Board of Trustees, the report of the Business Organization Committee particularly. I want to say that the Finance Committee has tried to do that same thing. We have scrutinized the expenses and have tried to cut them down to the very lowest limit.

The budget we have recommended is approximately the same as last year. I shall go through the tiresome procedure of reading it for your edification.

Dr. North read the requested budget for the year 1941-1942.

See page 19.

PRESIDENT MORRIS: That will be referred to Committee "C".

Action: See page 12.

Are there any other supplementary reports?
Is there any new business?

CONSTITUTIONAL AMENDMENT

DR. MARCUS W. NEWCOMB (Burlington County): I want to offer an amendment to the Constitution under new business.

Dr. Newcomb read the following proposed amendment to the Constitution, involving a change in Article VII:

Proposal to make the President of the Society an ex-officio member of the Judicial Council.

In the Constitution change Article 7 by inserting in the sixth line after the word "collectively" the following words: "together with the President, who shall be a member ex-officio".

In the By-Laws, Chapter 7, Section 1, add at the end of the section after the word "years", "The President shall be a member of the Council ex-officio".

Dr. Newcomb concluded with the following remarks:

This is to make the President a member of the Judicial Council ex-officio.

When I was President of the Medical Society, the Judicial Council heard a case and I asked to know what the testimony had been. They told me that that information was for the Judicial Council only and was confidential.

It seems to me that the President of this Society can keep any matter as confidentially as the Judicial Council can. If you cannot trust your President to hold things confidential, then you had better not elect him President. I cannot see why anything done by any committee or any Judicial Council of this State Society should not be available to the President, so he will know what is going on.

I don't think anything goes on in any business that the president of the firm cannot know all about.

This does not do the Past Presidents any good nor the President at this time, but it will help the future presidents. If anything comes up before the Judicial Council, he will be able to sit in and hear the testimony and he will know what is going on.

PRESIDENT MORRIS: This will be referred to the Committee on Constitution and By-Laws. Dr. Van Ness is Chairman. This is the only time for new business. Tomorrow is the election, and on the last session no new business can be discussed without suspension of rules.

Action: See page 16.

LEGISLATIVE RESOLUTION

SECRETARY STAHL: I think we all feel highly honored to have received this Resolution* from the Legislature of the State of New Jersey.

Secretary Stahl read this resolution (published on page 328 of June Journal) and concluded with the following remarks:

I think this ought to be framed and put in the office of our State Society. I also think that a motion that we acknowledge this in a proper way would be in order.

DR. WELLS P. EAGLETON (Essex County):

Few members here realize the importance of this communication. It is the culmination of twenty years' work by the medical profession with your legislative bodies. No other state society, and I say it advisedly, has ever received such a commendation for its work for the health of the people, for the benefit of the people, by the legislative bodies of the State, as herein expressed.

What does it show? It shows that for twenty years, year after year, representatives of your Society have been going to the Legislature and gradually the legislators, both in the Senate and in the Assembly, have begun to realize that whatever The Medical Society of New Jersey has advocated has been for the good of the State of New Jersey.

In my opinion, this is the greatest compliment that has ever been paid to the work, the spirit and the activities of The Medical Society of New Jersey. (Applause.)

SECRETARY STAHL: I think you ought to dispose of that in a motion.

DR. EAGLETON: I think a committee should be appointed to draw up a proper acknowledgment of this communication. It should not be simply a formal thing but it should state that we appreciate the honor that has been conferred upon us by the legislative representatives of New Jersey.

DR. HILTON S. READ (Atlantic County): My only suggestion is that as a means of practical machinery we allow our Legislative Committee, that has made these very fine contacts, to respond to this communication.

SECRETARY STAHL: While it would be a fine thing for the Legislative Committee to

formulate a proper reply, I think it should be sent through the President and attested by the President and the Secretary.

DR. EAGLETON: I agree with that.

PRESIDENT MORRIS: Do you make that a motion?

DR. EAGLETON: Yes.

PRESIDENT MORRIS: A motion has been made that the reply be formulated by the Legislative Committee and attested to by the President and Secretary of the Society and forwarded to the Legislature.

The motion was seconded and carried.

DR. ABRAHAM E. JAFFIN (Hudson County): Would it be out of order to have a transcript of Dr. Eagleton's remarks sent to the Legislature? I think it would be greatly welcomed by the Legislature. I make that as a motion.

The motion was seconded and carried.

PHARMACEUTICAL PROBLEMS

DR. ULMER: Mr. President and Members of the House of Delegates: In presenting this item, I do so in behalf of the Advisory Committee on Pharmaceutical Problems. In March, 1941, several pharmaceutical interests proposed an amendment to the Food, Drug, and Cosmetic Act which would require additional record-taking by physicians who dispensed drugs. It would require such physicians to keep a record of the name of the drug, the quantity dispensed, and the name and address of the patient. It would require the dispensing physician to label such drugs with a serial number, the date, the name and the address of the patient. Our Committee met on March 16th, 1941, to consider this. We opposed it because most physicians already keep a record of drugs they dispense. This is routinely done on the history card of each patient. Physicians also label dispensed drugs.

The Committee thought is advisable to present this to the House of Delegates when a greater number of physicians could express an opinion, since there was no apparent emergency for immediate action.

The Committee hopes that no legislation would be attempted that might disturb the present cordial relations between the pharmaceutical and medical professions in this State and that nothing would occur that might discourage the broad, constructive program now in progress by the Joint Committee on Professional Relations of our own State Society and the State Pharmaceutical Association.

Mr. President, although we have been assured that this amendment will not be introduced in the present legislative session, we

* See page 2.

should like an expression from this body endorsing our action and joining us in our opposition to this proposed amendment.

We should like to have this action recited on the minutes of this House of Delegates for use on any further occasion should the same problem arise.

DR. REEVE L. BALLINGER (Hudson County): I move that we go on record against this proposed amendment to the Food, Drug and Cosmetic Law, now in effect in the State.

I think it in keeping to explain a little of the background of this.

A doctor gave a patient a tonic which irked one of the druggists very badly. The druggist politely reported the doctor, and upon that occasion a letter in chastisement, I understand, was written to the physician by the State Board of Pharmacy or the State Pharmaceutical Association. The doctor reported the matter to his county society, which obtained an opinion from the Attorney General, saying that that part of the law passed last year did not affect the doctor, who has an inherent right, in his license, to practice medicine and to dispense if he so wishes.

However, there was a new resolution introduced in the form of an amendment, as Dr. Ulmer has already explained.

That is what precipitated our asking this body to go on record against such an amendment.

I make that a motion.

The motion was seconded, and unanimously carried.

PRESIDENT MORRIS: Is there any other new business? If not, I should like to say that we have planned to have all of the meetings of the Reference Committees tonight for one purpose: many men are interested in many of the reports. The committees are going to sit and listen to all suggestions and give full consideration to any suggestions from any members. I hope you will all take advantage of it. We have given the evening over to it so that these reports can be reviewed. On Thursday, we hope we shall be able to go through the usual procedure without any unnecessary discussion. Now we adjourn until twelve-thirty tomorrow afternoon.

The meeting adjourned at twelve forty-five o'clock.

MINUTES OF HOUSE OF DELEGATES

Wednesday Noon, May 21, 1941

The second session convened at twelve-forty o'clock, President Morris presiding.

PRESIDENT MORRIS: As you know, this session is just for the election of officers. Dr. McMahon, Secretary of the Nominating Committee, will read the report of that committee.

Dr. Bernard C. McMahon (Morris County) read the report of the Nominating Committee. (See below.)

SECRETARY STAHL: There is one correction. The fifth Delegate to the A. M. A. is for 1941 and 1942.

DR. MCMAHON: Yes, that is correct.

SECRETARY STAHL: The others are for 1942 and 1943.

REPORT OF NOMINATING COMMITTEE

For President-Elect: Dr. Elias J. Marsh.
For First Vice-President: Dr. Ralph K. Hollinshed.
For Second Vice-President: Dr. Joseph Londrigan.
For Secretary: Dr. Alfred Stahl.
For Treasurer: Dr. George J. Young.
For Councilors, three years:
Second District: Dr. Vincent Butler.
Third District: Dr. Chester Ulmer.
For Trustee, three years:
First District: Dr. William F. Costello.
Second District: Dr. Samuel Alexander.

Third District: Dr. George W. Fithian.

Fifth District: Dr. Aldrich C. Crowe.

For Trustee, one year to fill unexpired term:

Fifth District: Dr. David W. Green.

For Delegate to the American Medical Association:

1942-1943: Dr. Andrew F. McBride.

1942-1943: Dr. Lucius Donohoe.

1941-1942: Dr. Thomas K. Lewis.

For Alternate Delegate to the American Medical Association:

1942-1943: Dr. Spencer T. Snedecor.

1942-1943: Dr. Ralph K. Hollinshed.

1941-1942: Dr. Clarence W. Way.

For Delegates to other states:

To New York: Dr. D. Ward Scanlan.

To Connecticut: Dr. C. Byron Blaisdell.

To Pennsylvania: Dr. Marcus W. Newcomb.

For Alternate Delegates to other states:

To New York: Dr. Alfred Stahl.

To Connecticut: Dr. William G. Herrman.

To Pennsylvania: Dr. Emlen Stokes.

To Publication Committee: Dr. J. Lawrence Evans.

Each office was considered individually, and there being no other nominations, the candidates proposed by the Nominating Committee were declared unanimously elected.

The meeting adjourned at 12:50 p. m.

MINUTES OF HOUSE OF DELEGATES

Thursday Morning, May 22, 1941

The third session of the House of Delegates convened at ten thirty-five o'clock, the President-Elect, Dr. Thomas K. Lewis, presiding.

PRESIDENT-ELECT LEWIS: Will the meeting come to order.

Anybody who has been active in the Society appreciates the enormous amount of effort expended by our retiring President. We have all appreciated the opportunity and privilege of working with him. It is always with regret that we see the President leaving the active field of combat. We do not expect him to be inactive forever—just to take a year's rest and then be back in the game again.

It gives me great pleasure to introduce our retiring President, who will at this time render his address. (Applause.)

PRESIDENT MORRIS: At this time the suggestions outlined last June may well be evaluated. Probably the two most important projects of the year have been Medical Preparedness and the Medical Service Administration.

The Federal Government had delegated medical phases of its defense program to a committee of the American Medical Association, which in turn has called on the states to serve through sub-committees. The response of our members has been generous and gratifying. State and county committees and hundreds of members have worked diligently and, in most cases, without remuneration, in carrying out this program so that New Jersey stands well ahead of all the other states in the Union.

Our Legislators, having faith in New Jersey doctors, passed the enabling act setting up the Medical Service Administration, and it is now our duty to put it to work if we are to keep control over the practice of medicine in this state. If it succeeds we shall have a state plan to meet any proposed federal legislation. We must stand together and prove that we have the ability and will to carry such a program on to a successful conclusion. The Medical Service Administration is your organization and should be supported to the limit if we prefer to practice in the American way.

During the past year our relations with the public have been such as to have received recognition from practically all agencies interested in welfare. The Public Relations Committee has spread the philosophy to health workers and lay groups, and has met with signal success.

A bill to repeal the Medical Practice Act was introduced, which failed to pass. Credit for this is due our Legislative Committee and the Keymen in the counties who were able to present the dangers of this bill to the Legislators.

Our Maternal Welfare work is the envy of the world. Our Tuberculosis Case-Finding Program has met with general approval.

Problems of industrial health have received considerable attention from our state and county committees.

Post-Graduate Education is receiving more and

more attention, not only in New Jersey but throughout the nation. A national committee on Graduate Education is promoting plans to expand the scope of this work.

Medicine is under fire and is being carefully watched by those who would prefer to place it under federal control. One solution to the problem may well be in keeping the profession well informed as to the latest and best modern methods of treating the sick.

Whatever has been accomplished during the past year has been due to the keen interest and loyal support of the members, committees, and officers, for which I thank you.

PRESIDENT MORRIS: At this time it is always our happy privilege to introduce our President-Elect. I am sure he does not need any introduction. He is a gentleman and a scholar. He has worked hard for the Society for many, many years. Without any further ado, I wish to present to you Tom Lewis. (Applause.)

PRESIDENT-ELECT LEWIS: In accepting the leadership of The Medical Society of New Jersey, I should face the next twelve months with temerity were it not for the fact that my administration will be supported by several hundred officers and committeemen who have proved their loyalty to my predecessors. I express my appreciation of the confidence placed in me and pledge my best efforts to the welfare of The Medical Society of New Jersey and to the best interests of organized medicine.

With Medical Preparedness and the Medical Service Administration (which are intimately related with practically every other activity of the Society) dominating the picture, no new projects are planned; we shall consolidate our position and streamline our activities in order to be prepared for any eventuality.

It is time to cease talking about state medicine in the abstract. Organized medicine must face facts and assume leadership. We have been through a major depression and are embarked on one of the greatest armament building programs of all times; we are piling up a huge national debt, and when the "shouting and the tumult dies" we shall be engulfed in chaos. Whether the democracies win or lose the war, it is still to be determined whether democracy, as we know it, will endure, and whether it will be able to cope with the vast job of reconstruction.

Out of these cataclysmic events will appear problems of profound importance to the doctor. New methods of distribution of medical care may be necessitated. But the profession must hold fast to two principles:

1. Every individual must have available the best possible quality of medical care.

2. The free practice of medicine, which in this country has produced a standard of medical practice higher than any that has yet been known to

man, must be preserved to whatever degree is compatible with the demands of a changing order. Organized medicine in America must accept its responsibility for the preservation of the democratic way of medical practice. I am confident that The Medical Society of New Jersey will accept this challenge and hold its position in the front ranks of leadership in American medicine.

The audience arose and applauded.

PRESIDENT MORRIS: I should like to say that we were happy in all of the Reference Committees on Tuesday night to find that there was, as far as I know, no dissension, no friction. Everybody was happy. Even our Finance and Budget Committee did not have a visitor. I think that is a splendid record.

SECRETARY STAHL: I have a telegram addressed to Watson B. Morris, M.D., President, Medical Society of New Jersey, Haddon Hall, Atlantic City:

I wish to add my congratulations to those of New Jersey State Legislature to The Medical Society of New Jersey on its 175th anniversary.

It is a very proud record which your organization has made, rendering service to the public over this period, which is ten years longer than the independent existence of our nation.

I wish also to congratulate you upon being the head of this organization in such a historic year of its existence.

Kindly extend my personal regards to the members and my best wishes for a successful convention.

CHARLES EDISON, Governor.

DR. G. BARTON BARLOW (Bergen County): I move that a letter of thanks be sent to the Governor.

The motion was seconded, was put to a vote and carried.

REFERENCE COMMITTEE "A"

PRESIDENT MORRIS: We shall now hear from Reference Committee "A". Dr. Allman!

Dr. Allman read the report of Reference Committee "A" which considered the reports of the President* (p. 212), the Board of Trustees (p. 214), the Secretary (p. 220), and the addresses of the President† (see page 10 of these Transactions) and the President-Elect (see page 10 of these Transactions).

Mr. President, our Committee moves the approval of all these reports and the approval of this report.

The motion was seconded, was put to a vote and carried.

REFERENCE COMMITTEE "B"

PRESIDENT MORRIS: Reference Committee "B", Dr. Read!

Dr. Hilton S. Read read the following report:

Reference Committee "B" considered the reports of the Executive Officer (p. 215), the Publication Committee (p. 223), and the Sub-Committee on Public Relations (p. 232).*

Your Committee carefully reviewed the report of the Executive Officer. We commend it in its entirety. We especially commend the innovation in the management of the technical exhibits effecting a saving of one thousand dollars a year to the Society.

We also approve and suggest the further elaboration of the idea suggesting the peculiar fitness of the Executive Officer as a Liaison Officer with other state and community professional groups.

New Jersey is fortunate in having an Executive Officer of such talent, of such genuine interest in the welfare of the Society and its doorbell-pushing members and the consumers of medical care in New Jersey. His state and national contacts are of incalculable value to this Society.

We are also unusually rich in the loyalty and ability of his staff.

We approve the report as a whole.

Your Reference Committee "B" has carefully studied the report of the Publication Committee.

We particularly commend the efforts toward economy especially in the periodic omission of the lists of officers and committees.

This Society owes an enduring debt to Dr. Henry C. Barkhorn, the Chairman of the Publication Committee, to the members of his Committee and to the Editor of the *Journal*, for making the *Journal* of The Medical Society of New Jersey a publication of such merit.

A communication was sent to the Reference Committee suggesting that the *Journal* of The Medical Society of New Jersey, or at least a Bulletin of The Medical Society of New Jersey, or of the County Medical Societies, containing the position of organized medicine in New Jersey relative to legislation, should be sent to the State Legislature. Your Reference Committee approves of this idea. The Executive Secretary of the Legislative Committee and the Keymen in the county are doing yeoman's service in keeping our legislators informed of the position of organized medicine in New Jersey. Purpose of sending the legislators the *Journal* or Bulletins is to plug any possible loop-holes.

We approve the report of the Publication Committee as a whole.

Your Reference Committee "B" has reviewed the report of the Sub-Committee on Public Relations.

We are unanimously of the opinion that we would be failing in our duty did we not especially commend the Chairman of this Committee. He took on this new work with an unparalleled degree of enthusiasm which throughout the year was matched only by the way in which he vigorously prosecuted his enthusiastic ideas to the credit and profit of The Medical Society of New Jersey.

We especially approve the philosophy of this Committee of cultivation of good community relations between the consumers and dispensers of medical care in this State rather than emphasizing health education.

We would further bespeak for the Public Relations Committee; the coöperation of the various County and State Societies in getting newsworthy announcements to the Public Relations Committee so that more attention-arresting publicity could be secured.

The Public Relations Committee should be further

* Italicized numerals refer to pages in the May *Journal*.

† Bold-faced numerals refer to pages in these TRANSACTIONS.

commended for its splendid releases not only to the *Journal of The Medical Society of New Jersey*, but to the various County Bulletins. The Chairman's article on "The McClave Act and You" is but a single example in point.

We specifically approve the five recommendations of the Committee and we wish to reinforce its words of appreciation for Dr. Morris' energetic Public Relations activities as our Society's Ambassador of Good Will.

I move the adoption of each part of the report and of the report as a whole.

DR. FRANK A. BIEN (Essex County): I should like to discuss the portion of the report in reference to sending copies of our *Journal* to the State Legislature.

It is the first time in years that there has been an amicable relationship between our legislators and the medical profession. It has been requested by the legislators of the State that we send them a *Medical Journal* three or four times a year so that we could inform them of the attitude of the medical profession in reference to medical bills that are presented.

One medical bill was presented before the Legislature that our Essex Assembly delegation thought that we favored. After we informed them that we were not in favor of it, the bill died in committee.

Inasmuch as our forefathers in the Society were interested in legislation, I think it is of paramount importance today in view of the chaotic condition of the world that we too take a little more interest in legislation. Since the legislators want to cooperate with the Society, I certainly approve of the report of Dr. Read in regard to sending the *Medical Journal* to our State legislators at least three or four times a year, thereby expressing the opinions of the Medical Society to our legislators.

PRESIDENT MORRIS: Is there any further discussion?

DR. READ: I move the adoption of each part of the report and of the report as a whole.

The motion was seconded, was put to a vote and carried.

REFERENCE COMMITTEE "C"

PRESIDENT MORRIS: Reference Committee "C", Dr. Schaaf!

Dr. Royal A. Schaaf read the report of Reference Committee "C".

Reference Committee "C" considered the reports of the Treasurer* (p. 221), the Finance and Budget Committee,² and the Medical Service Administration (p. 262).

The Reference Committee endorsed these reports.

DR. SCHAAF: I move the adoption of each part of the report and of the report as a whole.

* Italicized numerals refer to pages in May *Journal*.

The motion was seconded, put to a vote and carried.

REFERENCE COMMITTEE "D"

PRESIDENT MORRIS: Committee "D", Dr. Norton!

DR. HAMMELL P. SHIPPS (Burlington County): Dr. Norton was unable to serve and asked me to act as the chairman.

Dr. Shipps read the following report of Reference Committee "D":

REPORT OF REFERENCE COMMITTEE "D"

We have examined the Report of the Committee on *Medical Preparedness*.¹ It has been excellently prepared and gives some idea of the tremendous task which has confronted this committee. The thoroughness and efficiency with which the task has been performed is quite evident. With some sense of pride, we find New Jersey standing first in the nation in work done on Selective Service. Plans for the future indicate further important new work together with continuation of the present program. One of the new projects will be rewriting the manual of first aid.

To carry out the ever increasing program the Committee has found it necessary to employ a full-time secretary. At present the Committee has on hand a surplus of approximately \$1500, representing profits accrued from funds allotted from the Federal Government for x-ray. This is sufficient to buy a desk and typewriter and pay the secretary's salary for one year. It is suggested that the appropriation from our Society treasury be continued and that this amount be held as a contingent fund in case of some unusual requirement.

We heartily commend the excellent work of this committee and move you that the report be accepted, the requests be granted, and a vote of thanks be given.

The Committee has received letters of commendation and appreciation from Col. Charles Watson, Surgeon, Second Corps Area; William A. Higgins, Adj. General of New Jersey; Hon. William J. Ellis, Chairman of the Committee on Health and Welfare of the New Jersey Defense Council; Dr. J. Lynn Mahaffey, Director of the State Department of Health, and Mr. Audley Stephan, Chairman of the New Jersey Defense Council.

This Committee has requested that the House of Delegates, by formal resolution, extend its thanks to the above-named gentlemen for this evidence of their appreciation of their efforts. We so move.

DR. SHIPPS: I move the adoption of the report as a whole.

The motion was seconded, put to a vote and carried.

REFERENCE COMMITTEE "E"

PRESIDENT MORRIS: Next is the report of Committee "E". Dr. Cosgrove!

Dr. Samuel A. Cosgrove read the following report:

This Committee met May 20, 1941, there being

1. See page 256 of May *Journal*.

2. See page 19 of these TRANSACTIONS.

present the Drs. John W. Gray, Cedric C. Carpenter, Clarence W. Way and the Chairman of the Committee, and Drs. Ralph K. Hollinshed and Chester I. Ulmer.

By unanimous action of those present:

I. The report of the Committee on Annual Meeting was approved, and that Committee commended for its work. (See page 226.)*

II. The report of the Scientific Program Committee was carefully considered. Your Reference Committee approves the action of focusing the program on general sessions as a tentative policy at this session, but does not approved the permanent elimination of section meetings, nor the relegation thereof to Fall Clinical Meetings. (See page 227.)

Your Committee suggests as the scheme for scientific program for next year the following:

First day:

Morning—Meeting of House of Delegates.

Afternoon—General session.

Second day:

Morning (10 to 12)—Section meetings.

Noon—Election of officers.

Afternoon—General session.

Third day:

Morning (10:30)—House of Delegates.

It is further recommended that:

1. The sections represented be those already organized, or desiring to organize, subject to the approval of the Trustees. The number of such sections need not be fixed, as simultaneous meetings thereof will not tend to interfere in respect to the interest of members.
2. Section meetings will be primarily designed to develop the capacities of our own members. Guest speakers will therefore not be invited for such meetings except with the special approval of the Trustees.
3. Effort will be made to develop the "panel discussion" form of presentation at these meetings. Individual sections in their discretion might arrange their programs on the basis of two-hour sessions devoted either to—
 - a. Four short papers, with appropriate discussion periods; or
 - b. Two panel discussions under carefully selected leaders.

III. The report of the Committee on Scientific Exhibits (see page 228) is commended. It is recommended by your Reference Committee that the policy governing scientific exhibits should contemplate stimulation of exhibits from as many individuals and institutions in our own state as possible.

IV. Your Committee recommends that the 1942 convention dates be fixed in the discretion of the Board of Trustees, and that the meeting place be the Hotel Haddon Hall in Atlantic City.

DR. COSGROVE: I move the approval of the several reports dealt with and of this Reference Committee's report.

The motion was seconded, put to a vote and carried.

REFERENCE COMMITTEE "F"

PRESIDENT MORRIS: The next report is that of Reference Committee "F". Dr. Areson!

Reference Committee "F" considered the reports of the Welfare Committee (p. 228) and the Subcommittee on Legislation (p. 230).*

I move adoption of these reports.

The motion was seconded, put to a vote and carried.

REFERENCE COMMITTEE "G"

PRESIDENT MORRIS: Committee "G", Dr. Barlow!

Reference Committee "G" considered the reports of the Sub-Committee on Public Health (p. 241) and the Advisory Committees on: Cancer Control (p. 243), Venereal Disease Control (p. 254), Mental Hygiene (p. 250), Adult Health Supervision (p. 243), Tuberculosis Control (p. 252), Child Health (p. 246), Maternal Welfare (p. 248), Crippled Children (p. 247), Pneumonia Control (p. 251), Traffic Accidents (p. 251), and Conservation of Vision (p. 246).*

Report of Sub-Committee on Public Health—This Reference Committee approves the report in its entirety and wishes to commend the Public Health Committee on its excellent work. (Page 241.)

Report of Advisory Committee on Cancer Control—This Reference Committee approves the report, but wishes to make a few suggestions concerning the resolutions appended to that report. There are four resolutions. We heartily approve the first one. In connection with the second we would like to emphasize that the provisions to be made by the Department of Health be in complete coöperation with the Medical Society, and the control of studies be placed as far as possible in our hands to prevent outsiders from gaining control. To undertake this epidemiologic study, as recommended, would require a new bureau for the Department of Health, for which there are no funds. This would have to be considered. The third resolution states that the approval of the individual County Medical Society is necessary in each instance, and this Committee wishes to emphasize the local control rather than central control. This committee feels that the fourth resolution is ambiguous, that some of the counties in this state are not set up for cancer work, and therefore, the plan would have to be more locally defined. (See page 243.)

In general, this report of the Advisory Committee on Cancer Control shows a great deal of work, which this Committee wishes to commend highly.

Report of the Advisory Committee on Venereal Disease Control—We wish to commend this report to the Society, and would like to enlarge upon the proposal of the Bureau of Venereal Disease Control to do group blood testing in defense industries. We feel that the Committee has been a bit ambiguous in its report of consideration of this proposal. The County Society mentioned was anxious to have a general statement of state-wide policy about the matter, and this has not been given in the report. In our Reference Committee's discussion about this report it was stated that there is danger of the Bureau of Venereal Disease Control having to limit its educational program. The Reference Committee wishes to strongly urge that this phase of the Department of Health be definitely continued.

Report of Advisory Committee on Mental Hygiene—This Reference Committee wishes to approve this report in its entirety and to commend the Committee for its excellent work during the year. (P. 250.)

The Report of the Advisory Committee on Adult Health Supervision—The Committee wishes to commend this report and would like to emphasize a few points: The program for high school nutritional education should be worked out entirely with

* Italicized numerals refer to pages in May Journal.

the help of physicians; the matter of adult clinics should be worked out to allow the already existing clinics to develop a health examination department rather than to set up new clinics for this work anywhere in the state; the hospital plans for chronic diseases should be endorsed, but should be worked out with public funds rather than by means of private institutions. (P. 243.)

The Report of the Advisory Committee on Tuberculosis—This Reference Committee finds this report a very excellent one and merely has a few items to add, one being under the "Post Graduate Courses in Tuberculosis". We feel that announcement should be made for the refresher course given in Bergen County in April and May. Under "Case Finding in the Apparently Well", we feel that some statement should be made concerning the studies insofar as they affect indigent groups, groups who could pay at a reduced rate, and groups who are able to pay regular x-ray fees. (See p. 252.)

The Report of the Advisory Committee on Child Health—This Reference Committee highly approved the report and wishes to emphasize that future programs for child health committees in the various counties, such as were referred to the County Presidents last Fall, be more publicized throughout each county, and not take the chance of just being tabled as some apparently were last year. (See p. 246.)

The Report of the Advisory Committee on Maternal Welfare—This is an excellent report and the committee highly approves it in its entirety, and we wish to commend the Committee on Maternal Welfare for its excellent work. (See p. 248.)

The Report of the Advisory Committee on Crippled Children—This Reference Committee approved the report in its entirety and wishes to commend the Committee on its work. (See p. 247.)

The Report of the Advisory Committee on Pneumonia Control—This Committee apparently did not meet during the year, and your Reference Committee wishes to deplore this. We feel that at least one meeting should have been held during the year. The Reference Committee also points out that the funds for serum used for indigent cases were reduced last year and will probably be reduced even further during the next year unless some definite request is made. This Reference Committee feels that in spite of the widespread use of sulfanilimides in pneumonia there should still be available for use when necessary sufficient serum throughout the state. (See p. 251.)

The Report of the Advisory Committee on Traffic Accidents—This Reference Committee wishes to commend the report in its entirety and would like to add the specific mention of epilepsy under the request to require physicians to report certain pathologic conditions to the Commissioner of Motor Vehicles. (See p. 251.)

The Report of the Advisory Committee on Conservation of Vision—In reviewing this report, your Reference Committee commends it to the Society and wishes to approve the report in its entirety. (See p. 246.)

DR. BARLOW: I move the adoption of the report as a whole.

DR. FREDERIC J. QUIGLEY (Hudson County): Dr. Pollak, as Chairman of the Subcommittee on Legislation, would have me speak on the part of the report dealing with venereal disease control.

There was a bill introduced in the present session of the Legislature by Dr. Hargrave, of Essex, amending the section on treatment of venereal cases. The present law reads "any physician, nurse or other person treating venereal disease". The bill deletes the words "nurse or other person".

The bill passed the Assembly unanimously and is in the Senate and in the Committee on Public Health.

After it had passed the Assembly, I received a letter from a Mrs. Summers, who is in charge of public relations for the Christian Scientists. She suggested that the bill be amended so that it would not exclude treatment by Christian Scientists.

The present Medical Practice Act does provide an exemption for those who are treating by religious healing.

I discussed this matter with Dr. Pollak and our Trustee Adviser, Dr. Alexander, and wrote Mrs. Summers to the effect that this bill was not sponsored by The Medical Society of New Jersey but that we felt it was a very meritorious measure; however, before expressing an opinion, her letter would be referred to Dr. Mahaffey of the Department of Public Health.

I heard Dr. Mahaffey discussed the proposal with the Department of Venereal Disease Control and expressed opposition to any amendment to this bill, taking the very sound position that venereal disease being communicable, no one except a licensed physician should be empowered to treat it.

I wrote Mrs. Summers to that effect and stated that I felt sure that The Medical Society of New Jersey must subscribe to the viewpoint of the Department of Health.

Last month in the Legislature, Senator Sumnerill, Chairman of the Committee on Public Health, told me that an amendment would be offered in the Senate. The bill has not been reported out and he asked our position. I explained the whole thing to him just as I am explaining it to the House here and he asked if we would write him a letter to that effect.

Our feeling is that it is so important that perhaps it might be well if it could be included in the report of this Committee, if they felt so inclined.

Every senator has been contacted by the Christian Scientists and one of the state's best lawyers, Mr. McCarter of Newark, represents them. There is a considerable interest. Three senators asked me what I thought about it. I don't think they are very sympathetic toward the proposal but the political complications might incline them to favor the amendment.

DR. WELLS P. EAGLETON (Essex County):

I move you, Mr. Chairman, that the remarks regarding the request of the Legislative Secretary be incorporated in the report and become a part of the minutes of this session.

DR. QUIGLEY: I just wonder if the Chairman of Committee "F" would agree to that incorporation.

DR. BARLOW: I certainly would agree to its inclusion in my report, or do you wish the Chairman of the Advisory Committee on Venereal Disease to approve it? It would be a very excellent addition to my report and could be included in it.

DR. EAGLETON: There are two things that occurred in this report that are of moment.

One is reference to the fact that the reports we adopted here last year were simply received and passed on and that was the end of it.

The other point is that there is a danger of the Bureau of Venereal Disease Control being abolished. Is that so?

DR. BARLOW: No, Sir. The report states: "In our Reference Committee's discussion about this report it was stated that there is danger of the Bureau of Venereal Disease Control having to limit its educational program. The Reference Committee wishes to urge that this phase of the Department of Health be definitely continued." We do not want it cut if possible.

DR. EAGLETON: Now we pass this report and that is the end of it. We ought to put some kind of teeth in this if we believe that it should not be limited. At the same time we should make a motion that we are in favor of continuation of the Venereal Disease Educational Program, and this matter should be referred to our Welfare Committee with the instruction of this body that they take steps to see that it is not limited.

I think this passing of reports and then forgetting them without making any provision for machinery to carry through what is wanted, is a great weakness of the organization.

DR. SAMUEL A. COSGROVE (Hudson County): The matter that Dr. Quigley has brought up is one of imminence in the legislative program. It is more recent than the report of the Sub-Committee on Venereal Disease, and I am wondering if Dr. Quigley's purpose might not be more directly served by, instead of amending the report before us, the direct passage of a resolution by this House at this time embodying the considerations which Dr. Quigley has expressed. I so move you, Sir.

DR. QUIGLEY: I think that this is the most direct method, a resolution by this House, and I think it would have a very strong effect.

DR. WILLIAM H. ARESON (Essex County): I am fully in accord with this. This is a communicable disease and the Department of Health has absolute control over communicable diseases. I don't see how Christian Scientists can enter into the treatment of scarlet fever or smallpox; and they cannot enter into the treatment of venereal disease.

I will go with you, Dr. Quigley, all the way, but I think perhaps it is unnecessary and it may weaken our own position, because as a health measure, communicable diseases are absolutely under the control of the Department of Health.

DR. QUIGLEY: For Dr. Areson's information, you must recall that in the beginning I stated that the present law states that "any physician, nurse or other person".

Now, we must agree that nobody except a licensed physician should be treating venereal disease. They are making an issue of this thing and if they get away with it, why we have given tacit consent to their treatment.

DR. ARESON: I will withdraw my remarks. I am with you one hundred per cent.

PRESIDENT MORRIS: There is a motion on the floor. I think we shall vote on the motion to accept the report of Reference Committee "G", excluding this one item of venereal disease control and then discuss that separately afterwards.

The motion to accept the report of Reference Committee "G" was put to a vote and carried.

PRESIDENT MORRIS: We are now ready for a motion on the question of venereal disease control.

DR. SAMUEL A. COSGROVE (Hudson County): I should like to move you, sir, that this House of Delegates at this time oppose the amending of the present Act in committee of the Legislature (Assembly 402), which in turn amends the present law. The purpose of 402 is to tighten up venereal disease control and restrict treatment to licensed physicians. The purpose of the proposed amendment to that bill would be to reopen it to the operation of Christian Scientists and perhaps other religious cults.

It is moved that this body oppose any legislation having the effect of permitting the treatment of venereal disease by anyone but a licensed physician, and that Dr. Quigley, Executive Secretary of the Sub-Committee on Legislation, be instructed to advise the legislators of the action of the House of Delegates as of this date (May 22, 1941).

The motion was put to a vote and unanimously carried.

DR. WELLS P. EAGLETON (Essex County): Now, may I introduce a resolution that the section pertaining to the possibility of the Bureau of Venereal Disease Control being limited in its educational program, be referred to the Welfare Committee with instructions that they are to use their best efforts to prevent such a restriction. May I offer that, Sir, at this time?

The motion was seconded, put to a vote and carried.

REFERENCE COMMITTEE "H"

PRESIDENT MORRIS: Report of Committee "H"!

Dr. Knauer read the report of Committee "H", reviewing the reports of the following committees: The Sub-Committee on Medical Practice (p. 233), the Advisory Committees on: Hospital Relationships (p. 235), Contract Practice (p. 235), Medical Care of the Indigent (p. 239), Nursing and Nursing Education (p. 239), Workmen's Compensation (p. 240), Auxiliary Medical Services (p. 234), Pharmaceutical Problems (p. 240), and Industrial Health and Hygiene (p. 236).*

The Committee endorsed the reports of the respective committees.

I move the acceptance of this report.

The motion was seconded, was put to a vote and carried.

REFERENCE COMMITTEE "I"

PRESIDENT MORRIS: Report of Reference Committee "I" by Dr. Comando!

Reference Committee "I" considered the reports of the Judicial Councilors (p. 219), and the Medical Defense and Insurance Committee (p. 222).*

Dr. Comando recommended that the reports be accepted.

I move the adoption of this report.

The motion was seconded, was put to a vote and carried.

REFERENCE COMMITTEE "J"

PRESIDENT MORRIS: Committee "J"! Is Dr. Featherston here? (No response.) Is anybody here to report for his committee? (No response.)

To Reference Committee "J" was assigned consideration of reports of the following committees: The Advisory Committee to the Woman's Auxiliary (p. 225), and the County Society Presidents (p. 265).*

REPORT OF REFERENCE COMMITTEE "K"

PRESIDENT MORRIS: Committee "K", Dr. Johnson.

Reference Committee "K" considered the reports of the State Board of Medical Examiners (p. 263), and the Post-Graduate Education Committee (p. 225).*

We recommend that the reports be accepted with thanks.

COMMITTEE ON CONSTITUTION

PRESIDENT MORRIS: Special Reference Committee on Constitution and By-Laws, Dr. Van Ness.

DR. VAN NESS: The Special Reference Committee on Constitution and By-Laws recommends the adoption of the proposed changes in the Constitution and By-Laws, namely:

Proposal to make the President of the Society an ex-officio member of the Judicial Council.

In the Constitution, change Article 7 by inserting in the sixth line after the word "collectively" the following words: "together with the President who shall be a member ex-officio".

In the By-Laws, Chapter 7, Section 1, add at the end of the section after the word "years" "The President shall be a member of the Council ex-officio".

DR. VAN NESS: The Special Reference Committee on Constitution and By-Laws recommends the adoption of this report. I so move.

The motion was seconded, put to a vote and carried.

PRESIDENT MORRIS: Dr. Marsh, is there anything under the Special Reference Committee on Credentials?

DR. ELIAS J. MARSH (Passaic County): Mr. President: I have no particular report to make. The Committee on Credentials is supposed chiefly to hear any contests and there have been no contests that I know of. None has been brought to our attention.

COMMITTEE ON RESOLUTIONS

PRESIDENT MORRIS: Special Reference Committee on Resolutions and Memorials, Dr. Burkett.

Dr. Wendell J. Burkett read the following report of the Special Reference Committee on Resolutions and Memorials:

REPORT OF THE REFERENCE COMMITTEE ON RESOLUTIONS AND MEMORIALS

Submitted to the House of Delegates of The Medical Society of New Jersey, May 22, 1941

Committee meeting May 21, 1941. Those present were Drs. Scanlan, Thompson and Burkett.

Resolution No. 1—Introduced by Dr. Thomas Lee of Camden County.

Dr. Helen Schrack of Camden spoke before the Committee regarding this resolution and urged its adoption by our Society. She further stated that the New York Academy of Medicine has approved a similar resolution, and that the New York State Medical Society had unanimously adopted it. She emphasized the salient points as embodied in the resolution and hoped that The Medical Society of New Jersey would adopt it in its entirety. Dr. Schrack is Regional Representative of the North Atlantic States of the American Medical Women's Association.

* Italicized numerals refer to pages in May Journal.

The Committee favored the adoption of this resolution and also felt that women physicians, when called by the Government for service, should receive the same rating and protection as the present members of the Medical Corps of the Army and Navy.

Resolution No. 2—Introduced by Dr. Comando of Essex County.

The Committee felt that the purpose of this resolution was to be commended but that the manner in which it was presented did not fill the required needs as they exist today.

The Committee suggests that the \$2,000, as mentioned in the resolution, or a sufficient sum, be recommended to the Board of Trustees and that the amount be returned to the component societies and thence to each individual member who is now in active service. The Committee feels that a set amount of \$2,000 would be inadequate to cover even the state dues as represented by the number of men who are now in the active service as members of the State Society. The present official program presents the names of over 130 men as being in the active service, and with the dues at \$16 a year, one can readily see that this amount is not sufficient to cover even the immediate needs. The Committee feels that the proper approach to this problem is one of exemption from dues while a member is on active duty and, therefore, recommends during this emergency that every member of the Society who is on full-time, active duty in the Army and Navy be exempted from further dues in the Society and that the same exemption apply to those who may be called to active service in the future.

Resolution No. 3—Introduced by Dr. Reeve Ballinger for the Hudson County Medical Society.

The Committee recognizes the purpose and thought as expressed in this resolution but cannot approve the adoption of the same before the House of Delegates today. In view of the fact that the Committee is not cognizant of the facts which prompted the formation of this resolution, it recommends that the resolution be referred to the Board of Trustees for a complete study and action.

DR. ELIAS J. MARSH: Mr. President: I should like to say that while I am in sympathy with the purpose of the resolution in regard to the relief of men in military and naval service from the expense of membership, the plan proposed by the Committee just now is not lawful under the Charter. No individual pays dues and consequently cannot be exempted. The assessment is made on each County Society as a unit on the basis of its membership, and consequently it is not possible to exempt individuals.

I think that some method could be worked out whereby these men could be helped. If it is satisfactory to the Committee, I would move that, as a substitute, the House of Delegates look with approval on the idea of financial relief for the men who are in service and that the matter be referred to the Committee on Finance and Budget and the Board of Trustees.

DR. BURKETT: The Committee felt that there was a possibility that the question of whether it would be legal would come up, but nevertheless the Committee recommended it as its view. We accept the suggestion of Dr. Marsh.

DR. FRANCIS C. WEBER (Essex County): Essex County has always felt that it is a play of words as to whether it is dues, assessments or whatnot and we feel that there should be a stronger expression of approval of this resolution. We should like it specifically understood that the men in service do not have to pay.

DR. BURKETT: Mr. President, may I say that he makes the statement that the men who are in service—

DR. WEBER (interposing): Or who have to go in.

DR. BURKETT: I understand. But the Committee felt that this exemption should apply only to those men who are on full-time active service, because some men now in the Army and Navy are spending part of the day on governmental duties and are then returning to their homes and practices at night or over the week-end, and are thereby not robbed completely of their finances.

If a man is in such a position, we don't feel that he should be exempted from his dues to the State Society. If he is taken in on full-time service so that his income is reduced—

DR. WEBER (interposing): We accept.

PRESIDENT MORRIS: I think we shall act on the first resolution as presented.

DR. BURKETT: The first resolution dealt with women physicians who might be called into Army and Navy service. I move its adoption.

The motion was seconded and carried.

DR. BURKETT: The second resolution dealt with the members on active duty in the Army or Navy. It directed that their dues be refunded to the various component county societies and that the Board of Trustees be instructed to set aside a sum of two thousand dollars for this purpose.

We don't feel that that should be done. I move the adoption of that recommendation.

DR. WELLS P. EAGLETON (Essex County): First of all, I think that every man in this room agrees that no man on full-time active duty, giving his time to the government, should be compelled to pay dues. There is a technicality involved; that is, it is more than a technicality, it is a principle. Cannot this matter be

voted on something like this, that this House of Delegates is heartily in accord with the principle that the men who are called to full-time active duty should be exempted from dues, but in view of the Constitution it should be referred to a committee consisting of the introducer of the resolution, Essex County, the former Treasurer, Dr. Marsh, and the Chairman of the Committee on Resolutions and Memorials, and this committee shall make a report to the Board of Trustees? I move we go on record in favor of the principle; the machinery we leave up to them.

The motion was seconded, put to a vote and carried.

DR. BURKETT: The third resolution† was the one presented from Hudson County, differentiating between a psychologist and a psychiatrist. We feel that this matter should be referred to the Board of Trustees.

DR. QUIGLEY: This is a rather important matter, because they are passing legislation in other states which gives a status to psychologists which they should not enjoy. They are putting them in positions which only a trained medical man with psychiatric experience should occupy.

If it is to be referred to the Board of Trustees, I suggest that it be referred with the instruction that the matter is extremely important, because psychologists are banding together and are looking for increased privileges.

DR. RALPH K. HOLLINSHED (Gloucester County): I suggest that this matter, instead of being referred to the Board of Trustees, be referred to the Committee on Medical Practice and the Welfare Committee.

DR. REEVE L. BALLINGER (Hudson County): There seems to exist in the State many school teachers who have taken courses in psychology and are holding positions that should be occupied by psychiatrists. There is a tendency for the State Department of Education to allocate positions to psychologists, and that is what was in back of this resolution. We felt that these positions should be entirely in the hands of medical men rather than school teachers and other educators who have taken courses in psychology. That was our sole purpose.

We certainly acquiesce to anything that the Reference Committee suggests and that this body desires. But I feel that inasmuch as this matter is very important at this time, there is no use talking about it after the harm has been done.

DR. EAGLETON: Those of us who were in the service during the last war should not forget that a group of men who had no medical training whatsoever, highly intelligent men, went down to Washington and received instructions from which they were supposed to be able to put an intelligence rating on every soldier and every officer in the whole United States Army. In the hands of a group of men was placed the power to examine their intelligence and so rate them.

Now, are we so foolish as to allow that thing to be sprung on us again and to dodge the issue? I think this passing it over to the Board of Trustees to investigate it, is not right. I think we should not sidestep this issue. I am wholeheartedly in accord with Dr. Ballinger when he says that a psychologist in order to qualify for the rating which he is given in the United States Army and the school system should be possessed of the degree M.D. and recognized by some state to practice.

I do not believe in dodging the issue.

PRESIDENT-ELECT LEWIS: I agree with Dr. Eagleton that this matter can and should be settled here.

One point has not been mentioned and that is that if we let this get by and permit the psychologists to diagnose and treat men, we are weakening our Medical Practice Act, which we must protect.

Dr. Burkett then read the resolution† and concluded with the following remarks:

Mr. President, may I add that the Committee feels that this is an excellent resolution but, not knowing the underlying facts, we thought it could best be taken care of by the Board of Trustees or through the committee to which the Board might refer it. That was the reason for our recommendation.

PRESIDENT-ELECT LEWIS: Mr. President, I move you that this resolution be adopted.

The motion was seconded and unanimously carried.

DR. BURKETT: Mr. President, I move you the adoption of this full report with the recommendations.

The motion was seconded, put to a vote and carried.

DR. BURKETT: Mr. President, I have one resolution which I read with regret.

Whereas, Dr. Frank Overton, for many years associated with The Medical Society of New Jersey as Editor of the *Journal*, is as of May 31st, 1941, retiring from that office; and

Whereas, He has rendered many services to The Medical Society of New Jersey as Editor of the *Journal* and as a "Good Will" Emissary of the Society; and

† See page 5 of these TRANSACTIONS.

Whereas, His efforts have been untiring in gathering historical data of value and interest to The Medical Society of New Jersey; and

Whereas, His work has been invaluable in creating an index of the Transactions of the House of Delegates and Board of Trustees; therefore

Be It Resolved, That this Board of Trustees of The Medical Society of New Jersey expresses to Dr. Frank Overton its deepest appreciation for the work so cheerfully performed and extend to him their best wishes and good cheer for the future, and further

Be It Resolved, That this resolution be included in the annual report of the Board of Trustees.

DR. EAGLETON: I move adoption of this resolution. All here feel that that is a small tribute to a man who has rendered at a very difficult time a service the importance of which few realize, and I ask that all members who approve of this be asked to stand at this time.

The assembly arose and applauded.

The motion was seconded, was put to a vote and carried.

PRESIDENT MORRIS: Before we adjourn, I should like to present to you our Second Vice-President, Dr. Joseph Londrigan. (Applause.)

DR. LONDRIGAN: Mr. President: I want to take this opportunity to express the thanks of Hudson County for the honor you have bestowed upon us and we hope we shall prove our worthiness by the work that we will do for the Society. (Applause.)

PRESIDENT MORRIS: If there is no further business, I will declare the one hundred and seventy-fifth session of The Medical Society of New Jersey adjourned.

The meeting adjourned at twelve-fifteen o'clock.

THE MEDICAL SOCIETY OF NEW JERSEY

1941-1942 BUDGET

A. Administrative

A-1 Executive Officer	\$ 7,000.00
A-2 Executive Salaries and Wages: Office Manager and 3 stenog- raphers	5,980.00
A-3 Executive Office Expenses	1,800.00
A-4 Executive Office Travel	1,000.00
A-5 Rent of State Society Headquar- ters plus electricity	2,950.00
A-6 Treasurer's Expenses	150.00
A-7 Finance and Budget Committee...	50.00
A-8 Bonding — Treasurer, Publication Chairman, Executive Officer ...	89.00
A-9 Audit	300.00
A-10 Secretary's Expenses	1,900.00
Printing of Transactions	\$700.00
Printing of Official List	800.00
Secretary's Expenses	400.00
A-11 Unemployment Compensation Tax	600.00
A-12 Insurance (Compensation, Fire & Accident)	350.00

B. Journal

B-1 Publication of Journal	14,000.00
B-2 Cuts for Journal	500.00
B-3 Editor's Salary	2,500.00
B-4 Editorial Secretary	1,560.00
B-5 Journal Office Expenses	700.00
B-6 Editor's Travel	250.00
B-7 Medical History	100.00

C. Welfare

C-2 Welfare Committee Expenses	1,500.00
C-3 Legislative Committee	3,600.00
C-4 Public Health Committee	2,000.00
C-5 Public Relations Committee	1,500.00
C-6 Medical Practice Committee	1,000.00

D. Special

D-1 President's Contingent Fund in- cluding secretarial assistance ..	3,000.00
D-2 A. M. A. Delegates (1941—Cleve- land)	200.00
D-3 Dues—Professional and Allied Con- ferences	50.00
D-6 Fall Clinical Conference	800.00
D-8 Woman's Auxiliary (ad interim fund)	510.00
D-11 Medical Service Administration ..	8,000.00
D-12 Medical Preparedness Committee ..	2,000.00
D-13 Post-Graduate Education Commit- tee	100.00

E. Contingent

3,000.00

F. Legal

1,500.00

G. Annual Meeting

G-1 Annual Meeting Committee	1,800.00
G-2 Scientific Program	250.00
G-4 Woman's Auxiliary	775.00
G-5 Scientific Exhibits	1,500.00

H. Pension to Dr. J. Bennett Morrison....

1,500.00

Total\$76,364.00

GENERAL ANNIVERSARY SESSION

May 21, 1941

The General Anniversary Session of The Medical Society of New Jersey was called to order by President Morris at 9:45 a. m.

PRESIDENT MORRIS: Last year, at my suggestion, the Trustees offered a prize of one hundred dollars and the privilege of reading an essay on any subject of interest to the general practitioner. A number of excellent papers were submitted. They were identified only by number and the Committee spent a great deal of time on them. They finally picked number 4 as the best essay of the group. This essay, written by Dr. Israel J. Wolf, Associate Pediatrician at the Barnert Memorial Hospital in Paterson, is entitled: "Treatment of Rickets with Massive Dose of Vitamin D." (To Dr. Wolf): Dr. Wolf, I have a check for you, and with much pleasure I present it and ask you to read your prize essay.

DR. WOLF: (Dr. Wolf's paper will be published in the September *Journal of The Medical Society of New Jersey*. It was a report of effective results in the treatment of rickets by the administration of single large doses of vitamin D. The author used ergosterol activated by electrical charges, and has given as much as 600,000 units in a single dose. Rapid improvement is reported. The treatment is characterized as simple, inexpensive, and ambulatory.)

PRESIDENT MORRIS: Dr. Wolf is to be congratulated on this presentation. I hope that the Administration next year decides to carry this on. It will be an inspiration.

As part of our Anniversary Meeting, the Annual Meeting Committee with the Trustees suggested that we have a general session this year and that it be a little out of the ordinary; that it be a review of the aims and activities of associated agencies which have to do with the welfare of our people. The various State Departments are well represented.

At this time I should like to introduce Dr. Mahaffey. He does not need an introduction to most of us. He is a member of our State Medical Society and Director of the Department of Health of the State of New Jersey. I take great pleasure in introducing Dr. Mahaffey.

DR. J. LYNN MAHAFFEY: Mr. President and Members of the Conference: I am very happy to appear on this program this morning. Your speakers are close friends of the State Department of Health; they work coöperatively with us. We have the greatest respect for Commissioner Ellis and his co-worker, Dr. Potter. Mr. Buch, of course we all know, and we applaud his work among crippled children. Dr. Smith is doing very excellent work in Belleville. Mr. Deardon is doing splendid accident-prevention work with Commissioner Magee. Of course, we all know Dr. Pollak. I have admired his work on tuberculosis for the last 25 years.

Dr. Mahaffey then presented an address in which he characterized the medical profession as the "rock-ribbed foundation of all public health programs". Dr. Mahaffey explained that the peacetime structure of the Health Department of New Jersey could be swiftly expanded to any emergency basis when necessary. He pointed out that there were 565 rural health units in the state, many of them having inadequate local medical personnel. These units were supplied therefore by the state health department with district officers to help administer community health projects. Latest such unit was established in Burlington County, adjacent to Fort Dix.

Dr. Mahaffey estimated that of the 184 million dollars paid to the U. S. Government in taxes from New Jersey residents, 74 million came back to New Jersey in grants or other forms, a substantial proportion of which went to health activities. He praised the good contact between New Jersey and Federal health agencies, and stressed the fact that the Federal as well as the local government recognized the importance of the individual medical man in public health programs. Exemplary of the expansion of New Jersey's public health program is the sky-rocket rise of health expenditures by the state department from \$450,000 in 1937 to \$1,100,000 last year. Dr. Mahaffey urged wider use of the social service facilities of the state health department by private practitioners in the follow-up treatment of venereal infection, and gave assurance that such procedure would in no way affect the privacy of the doctor's relations with his patients.

PRESIDENT MORRIS: Our second speaker also needs no introduction. He is Mr. William J.

Ellis, Commissioner of the New Jersey State Department of Institutions and Agencies.

COMMISSIONER ELLIS: Dr. Morris and members of The Medical Society of New Jersey: I am happy to be here and to share the program with Dr. Potter, Director of our Division of Medicine. Dr. Morris asked me who was going to speak first in the divided time assigned to us. Dr. Wilkes, however, had arranged that in his usual diplomatic way, because in discussing the question, he suggested, "The lady ought to have the last word." So, Dr. Potter, in her usual competent way, will have the last word.

Commissioner Ellis described the goal of his department as curative rather than custodial, characterizing purely custodial care as the most expensive kind a state could bestow on its wards. Cheap in its initial cost, the expense snowballs until it becomes staggering in ultimate cost and incalculable in terms of human degradation. Commissioner Ellis praised the State Board of Children's Guardians for preserving the personal doctor-to-patient relationship in giving medical care to the children in its charge and cited this as an example of the effectiveness of publicly administered health care without state medicine. The ability of the public agency to use the private physician in his private capacity, he suggested, was an important element in the democratic process.

DR. MORRIS: Thank you, Commissioner. And now it is a great pleasure to introduce Dr. Ellen C. Potter, a member of The Medical Society of New Jersey, the Acting President of the Woman's Medical College of Philadelphia, and the Director of Medicine in Commissioner Ellis' Department.

DR. ELLEN C. POTTER: Mr. President, Ladies and Gentlemen: Mr. Ellis and I talked for at least five minutes about how to divide our time. I had not realized that Roy Wilkes, having been a school medical inspector with me in Pennsylvania years ago, had remembered the propensity of woman for wanting the last word, but I'm glad to have this opportunity.

Dr. Potter pointed out that The Medical Society of New Jersey was 82 years old before New Jersey had established its first state hospital. The medical profession, she said, was the continuing thread that ran through the entire history of New Jersey institutions. Her department, she pointed out, supervised 234 private institutions, housing over 20,000 persons, and stated that the standards of medical care in such institutions were the major determinants in the department's approval of licenses or renewals to private nursing homes and other private institutions.

Dr. Potter described the rendering of medical care by and through the state agencies as a happy medium between an impossibly expensive and totally unsupervised system of having all state wards select

their own doctors, on one hand, and a socialization of medicine on the other.

She invited the medical profession to place young graduate medical students in the state institutions as summer interns and resident physicians, pointing out that these institutions had an average of 3,000 minor and 500 major surgical operations a year.

PRESIDENT MORRIS: Thank you, Dr. Potter. Most of the doctors in our audience realize what a good preventive-medicine job your department is doing. You can be sure that The Medical Society of New Jersey will be glad to be of service in an advisory capacity especially in the problem of the care of the chronically ill.

The next speaker is the Chairman of New Jersey's nationally known State Crippled Children's Commission, Mr. Joseph G. Buch.

MR. JOSEPH G. BUCH: Dr. Morris, Members and Delegates of The Medical Society of New Jersey, Ladies and Gentlemen:

Every properly trained crippled adult in New Jersey has been placed in employment, explained Mr. Buch, who described New Jersey as a pioneer state in helping the cripple to help himself. Its crippled children's commission had five objects: (1) Registering all crippled children, (2) rehabilitating the child, (3) giving him an education, (4) supplying vocational guidance and (5) securing job placement.

New Jersey was the first state to require the reporting of all babies born with visible congenital deformities. These reports are confidential, and are not part of the public birth certificate. Crippled children are promptly referred to orthopedists whose recommendations are carried out. This has been done so efficiently that New Jersey is now the only state in the union that has no list of crippled children waiting for orthopedic evaluation.

New Jersey requires all crippled children to be educated and provides teachers for every hospital or center housing more than eight crippled children. Furthermore, the Commission provides a private part-time teacher for every home-bound crippled child, funds being diverted from the crippled children's commission to local boards of education for this purpose. More than \$90,000 was spent on this last year.

At the age of 16, all crippled children are referred for vocational training. The Rotary and Kiwanis clubs have cooperated magnificently in this and arrange for a trial of actual employment training. Thus last year 58 trained cripples were referred to the Kiwanis. Of these, 52 were placed in jobs and only one had to be removed. The commission's promise is that the cripple "will do the work just as well as a person not physically handicapped". Today there are nine jobs waiting the training of crippled adolescents. New Jersey was the first state to set up a special center for the study and care of cerebral birth palsy cases. Possibilities of even greater expansion in the crippled

children's program is envisioned as a result of Federal participation.

PRESIDENT MORRIS: Thank you, Mr. Buch. And now I take pleasure in presenting the Deputy-Commissioner of Motor Vehicles for the State of New Jersey, Mr. William J. Deardon.

MR. WILLIAM J. DEARDON: Mr. Chairman, Members of the Medical Society: Commissioner Magee and myself appreciate the splendid coöperation you have afforded us in allowing us to exhibit some of our safety literature. We also appreciate this opportunity of addressing you.

Mr. Deardon urged the physical and mental examination of all automobile drivers. The public has been making increasing demand for this type of examination, and the Motor Vehicle Department is happy to endorse the sentiment. In too many accidents, a discoverable, remediable defect of vision, hearing, coördination or other physical resource of the driver is a factor. Mr. Deardon felt that a single physical examination of the driver was not enough, and that periodic reexaminations were as necessary for the operator as for the vehicle. It is expected that the medical profession would play a major rôle in these reexaminations. Already the Legislature requires the examination of bus drivers, and it is expected that eventually all motor vehicle operators will be subject to such examination. Mr. Deardon hoped that doctors would not be "too sentimental" towards their patients in this type of work. Another problem in which the Motor Vehicle Department needs the coöperation of the medical profession is in the examination of drunken drivers and in the evaluation of incapacitating intoxication. The department has prepared forms for such examinations and urges police doctors and other physicians doing this work to use the forms.

PRESIDENT MORRIS: Thank you, Mr. Deardon. Our next speaker, Dr. Ellis Smith, is the Medical Director of the Essex County Isolation Hospital at Belleville, N. J.

In his address, Dr. Smith deplored the encroachment of government hospitals on the domain of the private medical practitioner, specifically condemning the establishment of private accommodations in city hospitals. He spoke of the educational opportunities which a hospital could afford, explaining that these institutions are in strategic position to promote the graduate education of the physician. The flat-rate hospital plan was described, and in general praised, but Dr. Smith did deplore the tendency of a few physicians whom he characterized as "medical prima donnas" to abuse the plan by calling for unnecessary laboratory work.

PRESIDENT MORRIS: Thank you, Dr. Smith. Our last speaker is the Chairman of our Committee on Legislation. He comes here, how-

ever, as a representative of the New Jersey Tuberculosis League, Dr. Berthold Pollak.

DR. BERTHOLD S. POLLAK: Mr. Chairman, Ladies and Gentlemen: I am delighted to have the fact of light alluded to. We know that there is a great deal of light to be shed on the tuberculosis phase of public health.

Dr. Pollak reviewed the history of tuberculosis with special reference to New Jersey, and pointed out that in addition to the State Sanatorium, 11 counties have institutions for tuberculosis, with a total capacity of 3,400 beds.

The death rate of this disease has tailed off from 180 to 44 per 100,000, so that only one-fourth as many deaths now occur from tuberculosis as in 1906 when the New Jersey Tuberculosis League was first organized. Dr. Pollak credited this improvement to the education of the public and the coöperation of the medical profession through the Medical Society.

While the speaker felt that the State was adequately covered with clinic and nursing service (with 87 clinic centers in New Jersey serving 43,000 patients), nonetheless the problem is not solved since only 10 per cent of the patients admitted to sanatoria are in the minimal stage, and 60 per cent are in the far-advanced stage.

Dr. Pollak paid special tribute to Dr. Jaffin, Chairman of the Advisory Committee on Tuberculosis of The Medical Society of New Jersey, stressing the services rendered by the Chairman and members of this Committee.

He reviewed the public school program of tuberculin testing and x-ray examinations. Other states have studied New Jersey's legislation and procedures in this field.

The program of submitting every draftee to a chest x-ray during the induction procedure was described and the gratification with which the Second Corps Area of the Army welcomed this experiment was indicated by a communication from the Surgeon General.

Dr. Pollak described the post-graduate courses in tuberculosis now available to New Jersey doctors.

He concluded with emphasizing the slogan of the Committee: "A good x-ray is your doctor's best aid in discovering early tuberculosis."

PRESIDENT MORRIS: We have time for a few questions. Is there anyone who would like to ask any of the speakers a question?

DR. STANLEY NICHOLS: After consultation with the incoming President of the Society, I wish to offer a motion. It is that the coöperative methods set forth this morning by the leaders of State public and private agencies with The Medical Society of New Jersey for better public health and welfare in this State be abstracted by the Executive Secretary of this Society and copies sent by the President of this Society to a selected list of national key individuals and agencies to demonstrate

how New Jersey meets her health and welfare policies in the traditional democratic way.

I offer that motion.

PRESIDENT MORRIS: Thank you, Dr. Nichols!

The motion was seconded, put to a vote and carried.

PRESIDENT MORRIS: Does anyone else wish to ask a question?

DR. ELIAS J. MARSH: I want not so much to ask a question of the speaker but to ask a question for consideration of the Society.

Of the various interesting points that have been brought out this morning, none I think is more important than the matter brought up by the Deputy Commissioner of Motor Vehicles, in relation to the possible physical disability of drivers who should be reexamined.

We all have experiences, I suppose—I know I do—with patients who come to our offices and we discover possibly an acute but more often a chronic condition which has developed which incapacitates the individual in regard to his ability to drive a car. The patients don't always realize it.

Now, the question is this: It may be that we should be required to report such a condition to the Commissioner of Motor Vehicles, but according to all the tradition of our profession and possibly according to the legal obligation, too, that is a private finding on the part of the physician, a matter of confidential information between the physician and the patient. Consequently, he is not, by ethics or law, allowed to report such a condition.

It seems to me that some action should be taken whereby if I find a person has corneitis or retinitis which has diminished his vision beyond the safety point, I should be allowed to report it to the Commissioner or some other proper authority.

Here is another aspect of that same condition. A patient is sent in from his place of work with a minor injury of the cornea, an abrasion or foreign body which has to be dug out and which requires not only the removal of the foreign body but a dressing over one eye. The man drives himself from the shop. He has got to be sent home and it may be that he has a long drive home. A man who has been accustomed all his life to using one eye can drive safely with one eye; but as to a man who has suddenly had a bandage placed over one eye, who is accustomed to binocular vision, I very much doubt that he is a safe driver.

All I can do is to warn the man to be careful and if he has far to go, to get somebody else to take him home.

I think that matter would have to be worked out between the Motor Vehicle Department and perhaps the Labor Department and the Medical Society.

PRESIDENT MORRIS: Are there any other questions? If not, I take this opportunity to thank them for coming here today and giving us such a wonderful presentation.

One of our older members has asked to have just a word. Dr. Prout!

DR. THOMAS P. PROUT (Summit, N. J.): I have been very glad to be here on this occasion of the one hundred and seventy-fifth anniversary of this Society. As the men spoke, I realized what I have been missing in not being here more frequently in the years that have gone by.

I was particularly interested in the things that Dr. Pollak told us. Back in the nineties I was asked to attend the national meeting of the Tuberculosis League. The death rate from tuberculosis at that time was given as 246 per 100,000 of population—246! It was very interesting to hear Dr. Pollak tell us that the death rate from tuberculosis in New Jersey is now 43 per 100,000.

I was also interested in the report of Dr. Mahaffey, that we are gradually overcoming syphilis. Perhaps we shall realize that in another twenty or twenty-five years—well, perhaps by the end of the century.

The fact that we are on the way with so many other things, as indicated in the other reports, is most encouraging.

I am a psychiatrist and we have gotten on the way just these last eight or ten years in dealing with our major problem, the problem of mental disease. I think in the next ten or fifteen years we are going to see some little reduction in the number of mental cases admitted to our State hospitals.

I want to see another thing accomplished. It is the proposition of getting some control over and having some control over the feeble-minded. The average physician sees two or three cases in the course of a forty-year period. I see them every two or three days. I give you my word it is an appalling proposition.

A man just told me fifteen or twenty minutes ago that a little while ago he attended a feeble-minded girl and delivered her of her second child.

Now, those are all problems that come right to the State and they are getting to be of such character that they almost promise to engulf the State unless we can take care of them. A physician in Summit came to me and asked,

"What am I going to do with this situation? A girl of thirteen is 'taking care' of eight boys, aged fourteen to sixteen. I don't know what we are going to do about it."

There is just one thing to do about that girl and then there is one thing to do about all those feeble-minded boys.

DR. LEROY A. WILKES: Dr. Morris, may I just bring out one thought before you close? Here is an opportunity for the medical profession to assist these official agencies to an even greater extent in taking care of the group which has neither the economics nor the intelligence which make it possible for them, on their own initiative, to seek the individual care of a physician. This broad statement is the basis, I think, of the concept of the relation

between private practice and the public departments. The problems in public health, the problems in mental conditions and in the whole field lie in the lower intelligence and the lower initiative and the lower economic levels. The departments help us to help them by discovering these cases that otherwise would never come in contact with the private physician. (Applause.)

PRESIDENT MORRIS: I am sure, Dr. Wilkes, that the Society will cooperate in all of these efforts.

If there is no other business, we will adjourn.

The election of officers will be held at twelve-thirty in this room.

The meeting adjourned at twelve-twenty o'clock.

SUPPLEMENTARY REPORT OF TREASURER

COMPUTATION OF ESTIMATED CASH SURPLUS AS OF MAY 31, 1941

Before Audit and Subject to Revision

Cash—May 13, 1941:		
Executive Offices		\$ 1,635.44
General Account		70,125.16
Publication Committee		999.19
		<hr/>
		\$72,759.79
Estimated Receipts from May 13 to May 31, 1941:		
Commercial Exhibit	\$ 140.00	
Publication	500.00	
		<hr/>
		640.00
		<hr/>
		\$73,399.79
Deduct:		
Assessments applicable to succeeding year 7/12 of \$62,224.00	\$36,297.35	
Accounts payable—estimated:		
Budget	7,400.00	
Annual Meeting	3,400.00	
Commercial Exhibits	520.00	
Balance due Medical Service Plan	2,000.00	
		<hr/>
		49,617.35
Estimated Cash Surplus		<hr/>
		\$23,782.44
Cash desired in surplus account		20,000.00
		<hr/>
Estimated remaining surplus		\$ 3,782.44

GEORGE J. YOUNG, M.D.,
Treasurer.

WOMAN'S AUXILIARY TO THE MEDICAL SOCIETY OF NEW JERSEY

I. PRE-CONVENTION BOARD MEETING

By MRS. BANKS S. BAKER, Recording Secretary, Camden, N. J.

The pre-convention meeting of the Executive Board was held on Tuesday, May 20, at the call of the President, Mrs. R. J. McDonald.

The minutes of the last meeting were approved.

The Treasurer's statement was read and filed. (See page 28.)

The President's report was read. (See page 26.)

Mrs. Ily R. Bier, reporting for the Art, Hobby and Medical Exhibit, announced that

the Exhibit this year had surpassed anything of the past.

Mrs. David B. Allman, Chairman of the Entertainment Committee, described the rolling chair ride available for the afternoon.

Mrs. Banks Baker was appointed a Delegate in place of Mrs. J. Irving Fort.

The President appointed Mrs. A. J. Casselman, Mrs. George A. Rogers and Mrs. Frederick A. Kinch to serve as members of the Auditing Committee.

II. FOURTEENTH ANNUAL MEETING

By MRS. BANKS S. BAKER, Recording Secretary, Camden, N. J.

The Fourteenth Annual Meeting of the Woman's Auxiliary to The Medical Society of New Jersey was called to order at 10 a. m., May 21, by the President, Mrs. R. J. McDonald.

The invocation was delivered by Reverend Henry Merle Mellon.

Mrs. A. G. Merendino, President of the Woman's Auxiliary to the Atlantic County Medical Society, delivered an address of welcome, to which a response was made by Mrs. O. R. Carlander, President-Elect.

Memorial service was conducted by Mrs. James A. Hunter for the following members:

Mrs. George Tracy—Burlington
Mrs. Helen C. McDermott—Camden
Mrs. Henry G. Holler—Essex
Mrs. Eleanor Pyle Moore—Hudson
Mrs. Mary J. Donohoe—Hudson
Mrs. Herbert Nafey—Middlesex
Mrs. H. H. Bowles—Union
Mrs. I. Lehrman—Union

The minutes of the last Annual Meeting were read and approved.

The Treasurer's report was read and approved. (See page 28.)

Mrs. A. J. Casselman reported for the Auditing Committee that the books of the Treasurer were in good order.

The Committee Chairmen reported, and reports were approved on motion.

The County Presidents reported and their reports were approved on motion.

A motion to raise dues to \$1.00 was rejected.

A motion to establish a central office with an Executive Secretary was rejected.

A motion to hold regional meetings was carried.

The following resolutions were approved:

1. Resolved, that the Woman's Auxiliary to The Medical Society of New Jersey here assembled hereby expresses its appreciation and thanks to the Woman's Auxiliary to the Medical Society of Atlantic County for its coöperation, assistance and hospitality and its share in providing for the comfort and entertainment of its members during this, our 1941 Annual Convention, in Atlantic City.

2. Resolved, that the Woman's Auxiliary to The Medical Society of New Jersey expresses its thanks to Mrs. David B. Allman and her co-chairman, Mrs.

James Mason, with the members of their committee, for the splendid program of entertainment which they have provided for our members and visitors during this Annual Convention of 1941.

3. Resolved, that the members of the Woman's Auxiliary to The Medical Society of New Jersey hereby express their appreciation to our President, Mrs. R. J. McDonald, and all her officers and chairmen of committees for the pleasant and efficient manner in which they have successfully accomplished the various duties that have devolved upon them during this closing year 1940-1941.

4. Resolved, that the Woman's Auxiliary to The Medical Society of New Jersey hereby expresses thanks to the management of Haddon Hall for its coöperation in providing meeting places and other comforts for the Auxiliary members and visitors during this, our Fourteenth Annual Convention here assembled.

5. Resolved, that the Woman's Auxiliary to The Medical Society of New Jersey hereby expresses appreciation and thanks to The Medical Society of New Jersey and its office staff for the assistance and coöperation they have given during this past year.

6. Resolved, that a resolution of sympathy be sent to each county suffering the loss of a member during the year 1940-1941.

Mrs. Meineke moved the adoption of these resolutions. Seconded and carried.

On motion of Mrs. C. B. Russell the Auxiliary voted to pay the out-going President's expenses to the Cleveland Convention.

Mrs. Hornberger reported a registration of 206 members.

The following were nominated to serve as members of the Nominating Committee:

Mrs. Don A. Epler—Essex
Mrs. George Knauer—Union
Mrs. G. R. Stamps—Atlantic
Mrs. R. N. Berke—Bergen

Mrs. G. E. McDonnel, Chairman of the Nominating Committee, submitted the following names for election:

President-Elect—Mrs. J. Howard Hornberger, Florence
First Vice-President—Mrs. Alvah W. Bickner, Rutherford
Second Vice-President—Mrs. W. D. Miningham, Newark
Secretary—Mrs. Banks Baker, Camden
Treasurer—Mrs. Thomas P. McConaghy, Camden
Directors for three years—Mrs. David B. Allman, Atlantic City; Mrs. R. J. Faulkingham, New Brunswick

There being no other nominations the candidates were declared elected.

The newly elected officers were installed, and there being no further business the meeting was adjourned.

III. PRESIDENT'S ANNUAL REPORT

By Mrs. R. J. McDONALD, Paterson, N. J.

During the year June, 1940, to May, 1941, the Woman's Auxiliary to The Medical Society of New Jersey carried on its activities under the guidance of our Advisory Committee, of which Dr. William K. Campbell was Chairman.

Dr. Watson B. Morris and the members of the Advisory Committee met in September to discuss plans for the year. The particular task which The Medical Society allotted to us was the increase of members in The Society for the Relief of Widows and Orphans and the appointment of a Chairman of Medical Preparedness in each county, and a corresponding chairman in the State Auxiliary.

Most counties coöperated in the plan for preparedness, and while some were not actively interested in The Society for the Relief of Widows and Orphans, others have added new members to this splendid society.

The Public Relations Committee has stressed educational programs, and has coöperated with the Medical Society by having county chairmen place posters and distribute questionnaires getting the reaction of people to the broadcasts held over a national network.

Health institutes have been stressed as a form of public meeting. Moving pictures on medical topics have been furnished to several counties on request.

Auxiliary members are serving on boards of Women's Clubs, in Parent-Teachers' Associations and many lay clubs. Properly informed on medical topics these women can be depended upon to help guard the interests of Organized Medicine.

The Auxiliary was also asked to aid the county societies in completing the questionnaires sent out by the American Medical Association, and to see that they were mailed as soon as possible to the office in Chicago. This request has been complied with throughout the counties in the state.

As has been the custom the Auxiliary was asked to arrange for the social features of the Annual Meeting.

We were asked to continue the accumulation of historical data. Much of this material will be used in the supplement to be printed in an Anniversary Bulletin.

The Auxiliary has coöperated in each of these six items presented to us as our share in the plans of The Medical Society for the year.

The Chairman of Legislation has kept in close touch with the Legislative Committee of the Medical Society. Information has been sent to the counties at stated intervals. It is encouraging to note the interest in this displayed throughout the counties.

The Finance Committee this year has made some

changes for the purpose of carrying on the financial affairs of the Auxiliary in a more business-like manner.

This year we have a paid-up membership of 940 members. Actually we have enrolled over a thousand members, but we now record with the National Treasury only the dues for the members for the current year, retaining the payment of advance memberships until the proper time. This makes our enrollment look smaller, but next year the figures will increase.

Chief project of the National Auxiliary has been the promotion of subscriptions to "The Bulletin".

Our quota was 227 subscriptions; to date we have 181 subscribers. I am hoping before the close of this convention to arrive at the goal set down for us.

The exhibits and compilation of medical history have been carried on with the usual degree of efficiency exhibited in the past by Mrs. Ily R. Bier. The result of her labor can be seen in the exhibit room.

This showing is made possible through the cooperation of the various county units.

Great stress has been placed upon Press and Publicity this year. Articles by many state chairmen have appeared in the State Journal.

The Editor of The Journal has commended us for the quality of material sent to him.

Publicity is an important factor in furthering the interest in an organization.

The groundwork for first-class publicity has been laid this year and no doubt will continue in the future.

Some form of philanthropy is carried on in every

county. Student loans, blood transfusion funds, Kiddie Keep-Well Camps, Red Cross and Help to Physically Handicapped Children.

The Historian is compiling the history of the Auxiliary. This is an arduous task; and only a person especially qualified for this kind of work can be successful.

New Jersey ranked first in her history. Success such as this is assured if the counties will follow the plan sent out this year.

There has been nothing spectacular accomplished during 1940-1941. I have endeavored to carry on the work laid down by my predecessors. I have tried to give particular attention to the little things for it is my belief that by taking care of small matters we will progress and improve. The accumulation of many small things well done will make for real growth in the Auxiliary.

At this time, I express my thanks and appreciation to each and every member of the Executive Board; everyone has been kind and helpful.

It has been a privilege to serve you. I shall look back upon this year as one in which I have learned to know, to respect and to love the women with whom I have been associated.

It has been a year of peace and harmony, and that in itself is something for which we should be thankful when all around us we find hate and discord.

I wish also to express thanks to Dr. Watson B. Morris, President of the Medical Society. He has been kindness itself. He has cooperated in every way possible. I hope that my successor may be as fortunate. Once again, may I thank you all and trust that we shall be together for a long time.

IV. POST-CONVENTION BOARD MEETING

Reported by MRS. BANKS BAKER, Recording Secretary

The Post-Convention meeting of the Executive Board of the Woman's Auxiliary to The Medical Society of New Jersey was held at Haddon Hall on May 22, 1941.

The meeting was called to order by the President, Mrs. O. R. Carlander. Minutes of the pre-convention meeting were approved as read.

The Treasurer, Mrs. T. P. McConaghy, submitted a statement which was filed.

The President announced the Committee Chairmen for the coming year. Mrs. Lippincott, as Program Chairman, will select the members of her committee.

Mrs. Major moved that stationery be printed for the coming year. Seconded and carried.

Mrs. Lippincott moved that, if the Treasury would permit, we pay the expenses of both the President and President-Elect to the Convention in Cleveland, and accepted the amendment

that we pay the railroad fare plus six dollars a day for the business sessions. Seconded and carried.

Mrs. Yaguda asked that the County Presidents meet with her following the meeting.

Mrs. McDonald stated that she had promised a prize to the county obtaining the most subscriptions to the Bulletin; and presented the prize to Mrs. Russell as representative of Passaic County for obtaining twenty-four subscriptions.

Mrs. Carlander announced that the October meeting would be in Camden County.

There being no further business the meeting adjourned.

Respectfully submitted,

MRS. BANKS BAKER,
Recording Secretary.

THE JOURNAL

OF

THE MEDICAL SOCIETY OF NEW JERSEY

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1. Knight, F., and Shelanski, H. A., "Treatment of Acute Anterior Urethritis with Silver Picrate," *Am. J. Syph., Gon. & Ven. Dis.*, 23, 201 (March), 1939.

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LUCIUS F. DONOHUE (1943)Bayonne

Alternate Delegates

ELMER P. WEIGEL (1942)Plainfield
LANCELOT ELY (1942)Somerville
CLARENCE W. WAY (1942)Fort Dix
SPENCER T. SNEDECOR (1943)Hackensack
RALPH K. HOLLINSHED (1943)Westville

A "PURE FOOD LAW" 75 YEARS OLD

Far older than any Federal or State pure food law is Breyers Pledge of Purity. For 75 years Breyers Ice Cream has been made in strict conformity with this pledge of "real cream, real cane sugar. No substitutes, fillers or artificial flavorings".



Consistently superior since 1866

THE NATURAL MINERAL WATERS OF SARATOGA SPA ARE OWNED AND BOTTLED BY THE STATE OF NEW YORK



SARATOGA SPA GEYSER WATER

for

Conditions of Excessive Exertion, Fatigue and Thirst

In conditions of dehydration the patient will find the *natural* carbonation of Saratoga Spa Geyser Water a stimulus to ingestion.

These saline-alkaline waters, as will be seen from the accompanying analyses, are richly mineralized—more so, even, than many artificially mineralized waters.

The sodium content in the Spa waters is a valuable element in dehydration, as it aids in holding water in the body.

The waters replace the chlorides lost in vomiting or diarrhea. Your patient will find Geyser Water especially palatable.

Professional literature on the Waters is available to all interested physicians. To those who wish, a physician's sample carton of 4 bottles will be sent on request. Please write on your professional letterhead. Address: W. S. McClellan, M.D., Medical Director, 159 Saratoga Spa, Saratoga Springs, N. Y.

Analysis of the Three Waters

(MINERAL PARTS PER MILLION)

Hypothetical Combinations	Geyser Water	Hathorn Water	Coesa Water
Ammon. chlorid	48.25	59.10	33.30
Lithium chlorid	21.07	64.49	46.43
Potass. chlorid	361.91	789.54	714.86
Sodium chlorid	2,010.48	8,594.84	4,233.14
Potass. bromid	9.23	160.00	13.90
Potass. iodid	1.10	4.80	1.36
Sodium sulphate	None	None	None
Sod. metaborate	Trace	None	Trace
Sodium nitrate	Trace	Trace	Trace
Sodium nitrite	Trace	Trace	Trace
Sodium bicarb.	2,213.78	424.71	1,331.15
Calcium bicarb.	1,829.14	3,380.84	2,519.74
Barium bicarb.	16.67	25.65	25.00
Strontium bicarb.	Trace	Trace	Trace
Ferrous bicarb.	9.94	40.07	5.86
Magnes. bicarb.	753.89	2,244.88	1,186.57
Alumina	7.14	4.98	6.37
Silica	19.40	14.40	12.80
Total	7,284.00	15,808.30	10,130.48

Look for the Seal of The State of New York on every bottle of the genuine waters of Saratoga Spa.



THE BOTTLED WATERS OF SARATOGA SPA

GEYSER • HATHORN • COESA

Full-Motioned, Lifelike **ARTIFICIAL HUMAN EYES**



We have the Enviably Reputation of "Really Knowing How" to produce that "Pleasing Cosmetic Effect" so desired by one wearing an Artificial Eye.

REFERRED CASES CAREFULLY ATTENDED

IT IS OF VITAL IMPORTANCE TO THE PATIENT'S FUTURE APPEARANCE THAT THE FIRST ARTIFICIAL EYE BE PROPERLY FITTED. IT IS IN THESE NEW CASES, WHERE UTMOST ATTENTION MUST BE GIVEN—AND OF WHICH WE HAVE MADE A SPECIAL STUDY.

Especially Made to Order Eyes by Skilled Artisans.

Also Eyes Fitted from Stock

SELECTIONS SENT ON MEMORANDUM UPON REQUEST.

FRIED AND KOHLER, INC.

"Specialists in Artificial Human Eyes Exclusively"

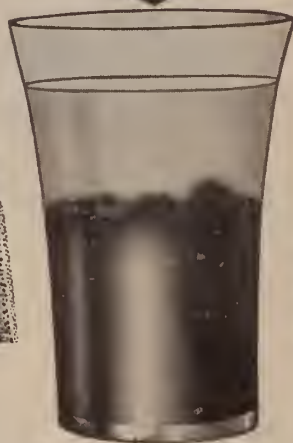
665 FIFTH AVENUE
near 53rd St.

NEW YORK, N. Y.
Tel. Eldorado 5-1970

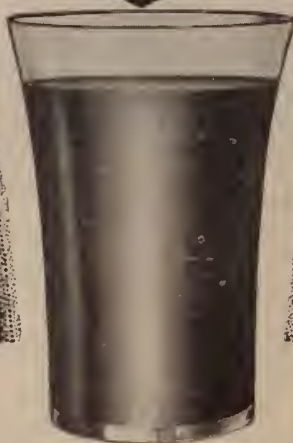
"Pleasing Particular People for Over Forty Years!"

Kemp's Sun-Ray **NEVER SEPARATES**

**IT'S NEVER
LIKE THIS**



**IT'S ALWAYS
LIKE THIS**



You see the difference between Kemp's Sun-Ray and tomato juices less carefully made. Kemp's Sun-Ray is always non-separating. The colorful tomato solids always remain in suspension because they are reduced to extreme fineness for easier digestion. Part of

Kemp's patented process No. 1746657 super-homogenizes and blends all the red-ripe solids of the whole, cored tomato with the liquid portion so that the juice is never thin or watery. . . . Enjoy the superb flavor and the whole-tomato consistency of Kemp's Sun-Ray at home, and recommend this tomato juice in your practice.

THE SUN-RAYED COMPANY • FRANKFORT, INDIANA
New York Agent: SEGGERMAN NIXON CORP., 111 Eighth Ave.



NON-SEPARATING . . .

Never **THIN OR WATERY**

PROFESSIONAL LIABILITY PROTECTION

Afforded Members of

THE MEDICAL SOCIETY OF
NEW JERSEY

Since 1921

FAULHABER & HEARD, INC.

Authorized broker to negotiate
professional liability contracts for
The Medical Society of New Jersey

CONSULT US

For Protection and Specialized Service

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FAULHABER & HEARD, Inc.

31 CLINTON STREET

NEWARK, N. J.

Kindly send information on limits and costs of Society Professional Policy.

Name

Address

.....

*An Excellent and Widely Specified Arsenical in
the Treatment of SYPHILIS*



Neoarsphenamine

MERCK

"Duty to the individual patient, even more than duty to the public health, demands the earliest possible diagnosis, as well as the earliest possible application of treatment."

(Supplement No. 6 to Venereal Disease Information,
United States Public Health Service, 1939)

NEOARSPHENAMINE Merck possesses physical, chemical, and biologic properties that reduce the possibility of toxic reactions to a minimum without depreciating spirocheticidal activity. When sprinkled upon the surface of the water, Neoarsphenamine Merck goes into solution immediately. It is meticulously ampuled.

Literature on Request

NEOARSPHENAMINE	
MERCK	
LOW TOXICITY	Council
RAPID AND COMPLETE	ACCEPTED AMERICAN MEDICAL ASSN. Council on Pharmacy and Chemistry
SOLUBILITY	Accepted

MERCK & CO. Inc. *Manufacturing Chemists* **RAHWAY, N. J.**

Are you familiar with this new FOUR-ACTION vaginal therapy?



BETANAL VAGINAL CAPSULES embody therapeutic principles of proven efficacy in the treatment of many leukorrheal disorders, including trichomoniasis, senile vaginitis, certain types of cervicitis, and cervical erosions.

The prompt efficacy of Betanal in vaginal therapy is due to its four-fold action:

1. Betanal promotes growth of normal flora.
2. Betanal aids in restoring normal acidity.
3. Betanal helps maintain epithelial carbohydrate.
4. Betanal acts to dry vaginal walls and promote healing.

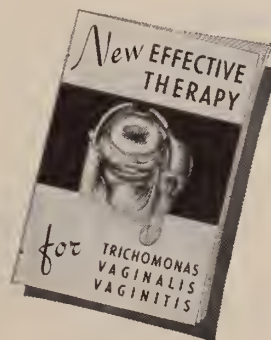
Betanal is convenient to use, contains no strong chemicals, is stainless, odorless, and non-irritating. Each capsule contains 220 gr. Borden's Beta Lactose and 55 gr. boric acid.

WRITE FOR BOOKLET DESCRIBING NEW BETANAL THERAPY

This descriptive booklet fully explains how the 4-point action of Betanal is effective in helping to restore natural vaginal defenses and promote healing. It also discusses the specific indications for prescribing Betanal, the method of use, and the clinical advantages in gynecological therapy.

FOR YOUR COPY of this booklet and sample of Betanal write The Borden Company, 350 Madison Avenue, New York, N. Y.

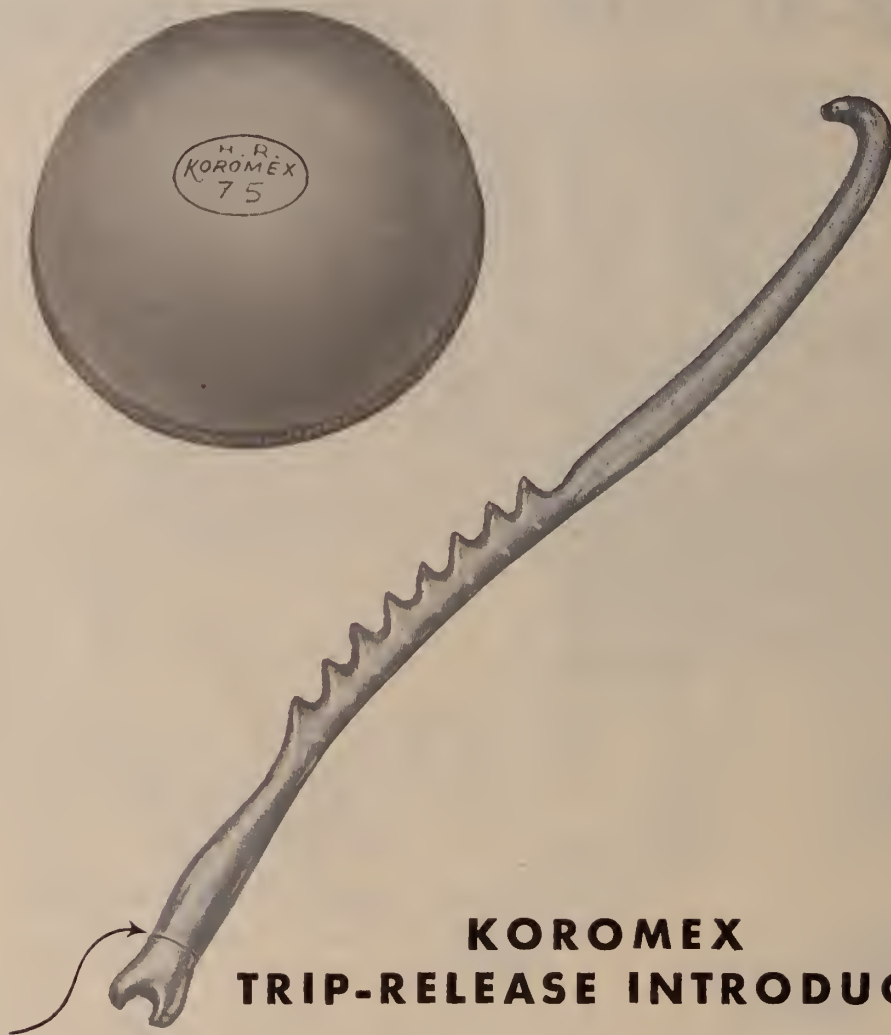
Betanal is available at any pharmacy in packages of ten capsules.



BETANAL VAGINAL CAPSULES

A BORDEN PRESCRIPTION PRODUCT

KOROMEX DIAPHRAGM



**KOROMEX
TRIP-RELEASE INTRODUCER**

TIP TURNS
ON SWIVEL

Holland-Rantos
Company, Inc.

551 Fifth Avenue

New York, N.Y.

As an Adjunct in the Treatment of ALCOHOLISM

ONE of the newest and most interesting uses for which Benzedrine Sulfate has been accepted by the Council on Pharmacy and Chemistry of the A. M. A. is as an adjunct in the treatment of chronic alcoholism and also in alcoholic psychoses, although best results are reported in states of intoxication in which no psychosis is demonstrable. The articles listed below represent the most comprehensive work which has been done to date in this field.

Reifenstein, E. C. Jr. and Davidoff, E.: The Treatment of Alcoholic Psychoses with Benzedrine Sulfate—J. A. M. A., 110:1811, 1938.

Reifenstein, E. C. Jr. and Davidoff, E.: The Use of Amphetamine (Benzedrine) Sulfate in Alcoholism With and Without Psychosis—N. Y. State Med. J., 40:247, 1940.

Bloomberg, W.: Treatment of Chronic Alcoholism with Amphetamine (Benzedrine) Sulfate—New Eng. J. of Med., 220:129, 1939.¹

¹Since this report, Bloomberg has enlarged his series to 60 cases which he reported on Dec. 28, 1940, at the annual meeting of the American Association for the Advancement of Science in Philadelphia. His results in this larger series were substantially the same as those in his original report.

ADMINISTRATION

Initial dosage should be small (2.5



to 5 mg.) and should be increased progressively until the desired effect is obtained.

IN CHRONIC ALCOHOLISM

the normal dosage used by Bloomberg was 20 mg. daily, one-half of the dose on rising and the other half at noon; but this was often adjusted to meet the requirements of the individual patient.

IN ALCOHOLIC PSYCHOSES

the normal dosage used by Davidoff and Reifenstein in institutionalized patients was 20 to 30 mg. orally or intravenously* in a single dose.

IMPORTANT! In prescribing Benzedrine Sulfate Tablets, please be sure to specify the tablet-size desired—either 5 mg. or 10 mg.

*Physicians wishing to use Benzedrine Sulfate Ampules may obtain them on direct order from us.

Benzedrine Sulfate Tablets



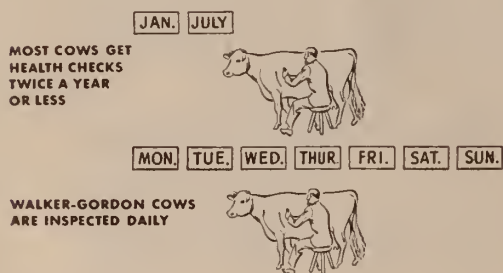
Brand of amphetamine sulfate

SMITH, KLINE & FRENCH LABORATORIES, PHILADELPHIA, PA.

Why are 54% of our customers sent to us by doctors?

● It may seem surprising that 54% of our customers have come to us on their doctors' recommendations. Surprising, that is, until you consider the facts.

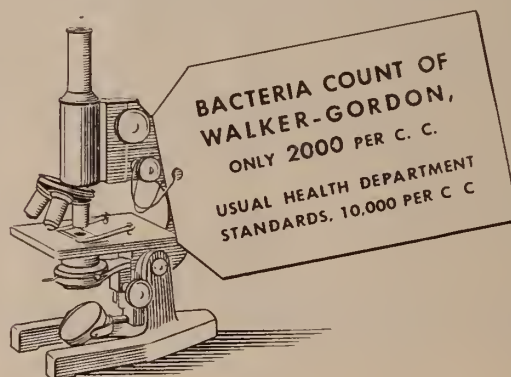
After all, the extraordinary purity precautions taken on our "clinically controlled" farms are well known to the medical profession. For example, Walker-Gordon cows are given *daily* health checks, instead of semi-annual.



Too, their udders are washed, and dried with sterilized towels, before each milking. And instead of being milked by hand, they're milked on the famous "Rotolactor" . . . an

exclusive Walker-Gordon development. Walker-Gordon Milk actually goes from cow to consumer without coming in contact with the outside air!

All of which helps explain why Walker-Gordon Milk is *five times as pure*, bacterially, as health departments require even under the high standards set for certified milk.



. . . And all of which helps explain, too, why Walker-Gordon is so widely recognized and recommended by doctors as *the world's finest milk*.

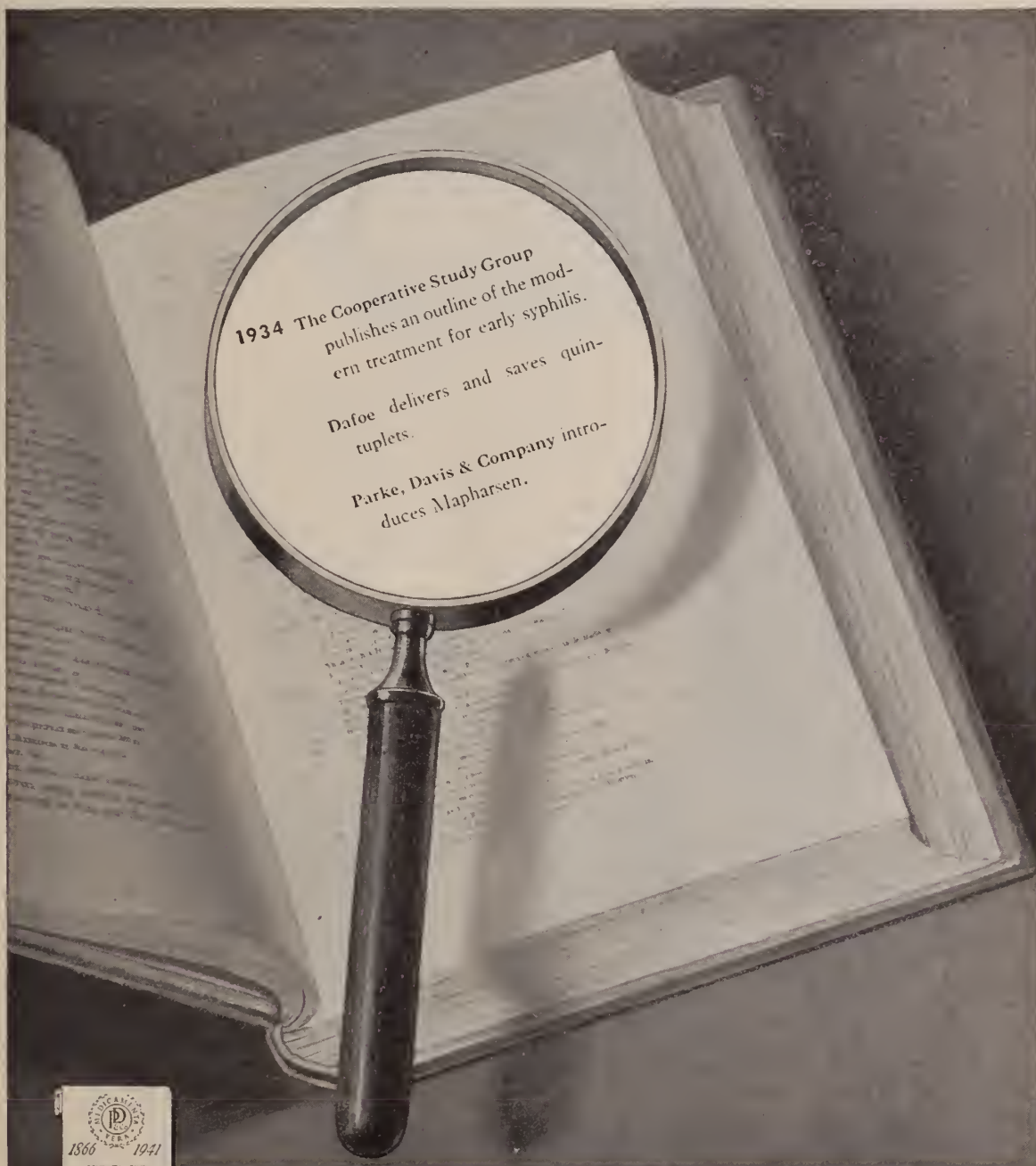
Walker-Gordon Certified Milk

THE WORLD'S FINEST MILK

AVAILABLE EITHER UNHEATED, PASTEURIZED, OR HOMOGENIZED

These names, these years have helped make modern medical history

One of a series of advertisements commemorating three-quarters of a century of progress and achievement

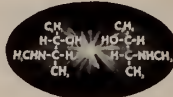


PARKE, DAVIS & COMPANY

PIONEERS IN RESEARCH
ON MEDICINAL PRODUCTS

RACÉPHEDRINE

in Fall Pollinosis



When efforts at desensitization have failed or been only partially successful in relieving hay fever or asthma, well-planned symptomatic treatment may bring welcome relief.

Solution Racéphedrine Hydrochloride (racemic ephedrine) is a reliable decongestant when applied to the nasal mucous membranes. Capsules Racéphedrine Hydrochloride may be given to prevent attacks and ameliorate their severity.

RACÉPHEDRINE HYDROCHLORIDE (UPJOHN)

Supplied in the following forms:

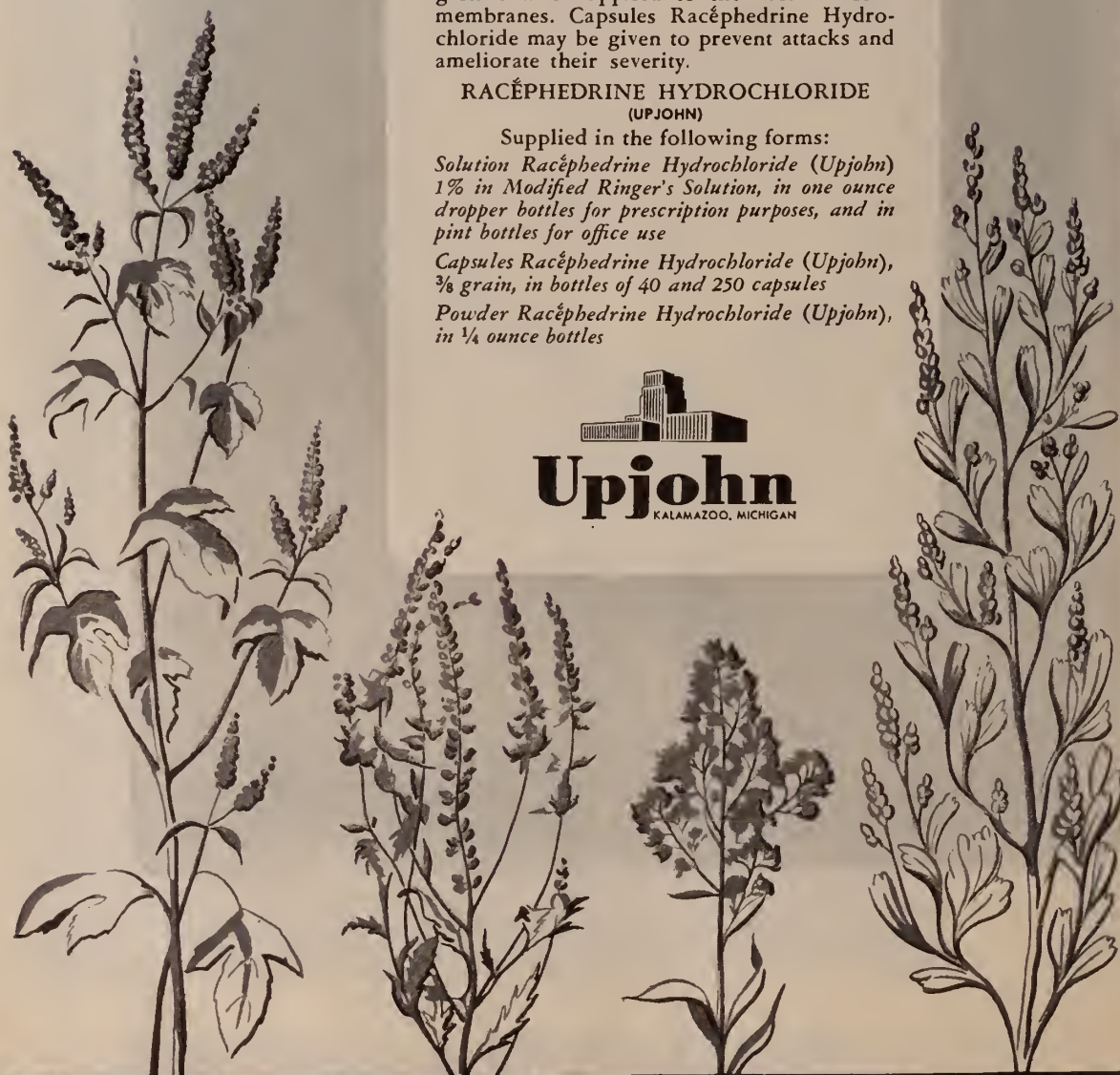
Solution Racéphedrine Hydrochloride (Upjohn)
1% in Modified Ringer's Solution, in one ounce dropper bottles for prescription purposes, and in pint bottles for office use

Capsules Racéphedrine Hydrochloride (Upjohn),
3/8 grain, in bottles of 40 and 250 capsules

Powder Racéphedrine Hydrochloride (Upjohn),
in 1/4 ounce bottles



Upjohn
KALAMAZOO, MICHIGAN



FINE PHARMACEUTICALS SINCE 1886



Q. I've heard that milk is a fine source of calcium. But what about canned milk?

A. Canned milk is an excellent source. In fact, canned milk, diluted with an equal amount of water, supplies the same amount of calcium and other minerals as whole, fresh milk. In addition, it is a valuable source of protein, fat and carbohydrate, vitamin A and the factor formerly designated as vitamin G (riboflavin). (1)

(1)

1940. Am. J. Pub. Health 30, 169.

1939. Food and Life, Yearbook of Agriculture, U. S. Dept. Agr., U. S. Government Printing Office, Washington, D. C., page 276.

1939. Accepted Foods and their Nutritional Significance, Council on Foods of the American Medical Association, Chicago, page 236.

1934. Am. J. Pub. Health 24, 194.



The Seal of Acceptance denotes that the nutritional statements in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

AMERICAN CAN COMPANY
230 Park Avenue, New York, N. Y.

Do You Know Your SULFONAMIDES?



SULFANILAMIDE

WHICH SHALL I USE
FOR GONORRHEA?

SULFAPYRIDINE

WHAT'S GOOD FOR "STREP"?

SULFATHIAZOLE

WHICH PRODUCES
BEST RESULTS
IN PNEUMONIA?MY PATIENT HAS A "STAPH"
INFECTION—WHAT SULFONAMIDE
IS MOST EFFECTIVE?

The sulfonamide compounds continue to grow in importance. Three separate drugs have been accepted by the Council on Pharmacy and Chemistry of the A. M. A. Another has been submitted for acceptance. We present on this page the "box score" on three "sulfa" drugs now in widespread use.

	Sulfanilamide N.N.R.	Sulfapyridine N.N.R.	Sulfathiazole N.N.R.
CHEMICAL NAME	(p-amino-benzene sulfonamide)	(2-sulfanilyl aminopyridine)	(2-sulfanilyl aminothiazole)
SOLUBILITY in 100 cc. of water at 37.5° C.	1480 mg.	54 mg.	96 mg.
PHARMACOLOGY	Relatively uniform and rapid.	Irregular and often poor.	Uniform—very rapid.
Absorption			
Distribution	In all body fluids.	In all body fluids.	In blood but poorly in other body fluids.
Excretion	Rapid.	Slower than Sulfanilamide.	Rapid.
Tendency to conjugation.	Slight.	Marked.	Moderate.
CHEMOTHERAPY			
★Preferred Drug.			
●Also Effective.			
Colon Bacillus			★
Dysentery Bacillus			●
Gonococcus		●	★
Lymphogranuloma Venereum	●	●	★
Meningococcus	●	★	●
Pneumococcus		★	★
Staphylococcus		●	★
Streptococcus	★	●	
HOW SUPPLIED BY SQUIBB			
Tablets	5 grain in bot. of 100, 500, 1000. 7½ grain in bot. of 25, 100, 1000.	0.5 gram in bot. of 50, 100, 1000.	0.5 gram in bot. of 50, 100, 500, 1000.
Powder	4 oz. Rx. bottle.	5 gram vials.	.
Crystals	1.0 gram ampuls, box of 5 and 25.		5 gram vials.
Capsules		0.25 gram in bot. of 50, 100, 1000.	

Specify
SQUIBB
sulfonamides

When you think of SULFONAMIDES
... think of SQUIBB



CHECKERBOARD TACTICS



Like men on a checkerboard, many people jump back and forth between the squares of optimum and minimum nutrition. Both the game of nutrition and the game of checkers are a matter of some luck . . . but more skill. To maintain desired health states it is well to depend upon the skill of application of modern nutritional knowledge. Maintenance of high standard dietaries can be accomplished with surprising ease if the simple rules of nutrition are observed.



COCOMALT finds its place in this dietetic scheme of things for both normal and therapeutic diets. Its rich flavor urges young and old to drink milk. COCOMALT contains calcium, phosphorus, iron . . . Vitamins A, B₁, D and G . . . quick energizing elements . . . body building nutrients. Recent studies and references* confirm these facts.

Cocomalt

is used more and more by physicians in diets for growing children and adults; for pregnancy and lactation; malnutrition, anorexia, pre- and post-operative patients, convalescence, febrile diseases and gastro-intestinal conditions.

C O C O M A L T
The Enriched Food Drink for All Ages

R. B. DAVIS COMPANY • Hoboken, N. J.

*Arch. of Ped.—56: Nov. 1939; Med. Record—Aug. 21, 1940;
Med. Record—150:1:1939; Arch. of Ped. 57:448 (July) 1940;
Med. Record—149: Jan. 1939; Surgery—6:1:1939.

RADON SEEDS



*f*OR safety and reliability use composite Radon seeds in your cases requiring interstitial radiation. The Composite Radon Seed is the only type of metal Radon Seed having smooth, round, non-cutting ends. In this type of seed, illustrated here highly magnified, Radon is under gas-tight, leak-proof seal. Composite Platinum (or Gold) Radon Seeds and loading-slot instruments for their implantation are available to you exclusively through us. Inquire and order by mail, or preferably by telegraph, reversing charges.

THE RADIUM EMANATION CORPORATION
GRAYBAR BLDG. Telephone MO 4-6455 NEW YORK, N. Y.



It makes their regular check-ups "fun" by giving youngsters some wholesome **CHEWING GUM**

It's such an easy, thoughtful gesture to always offer your little patients some delicious Chewing Gum while they're waiting or when they leave the office. They just love it—and it makes a big hit with adults, too. And for such a small cost this one, friendly, little act goes a long way in winning extra good will and affection. Besides, as you know, the chewing is an aid to mouth cleanliness as well as helping to lessen tension. Enjoy chewing Gum, yourself. Get a good month's worth for your office today.

V-201

**There's a reason, a time
and place for Chewing Gum**

NATIONAL ASSOCIATION OF CHEWING GUM MANUFACTURERS, STATEN ISLAND, NEW YORK

In early childhood . . .

Lederle's **CEREVIM**

CEREVIM, a pre-cooked cereal food, possesses those properties desirable in a first solid food for babies. Babies like it from the start, and because of its appealing taste, may be expected to continue eating it through early childhood. It is easily digested, highly nutritious and smooth in texture.

B Vitamins and Minerals from Natural Sources

Cerevim's comprehensive formula provides the B vitamins in generous amounts. Each ounce contains 100 International Units Thiamine (B₁) and 60 Bourquin Sherman Units Riboflavin (B₂). Calcium, phosphorus, iron and copper are provided in easily assimilated form; proteins, carbohydrates and fats in a suitable ratio—all derived from natural sources only.

- ready for instant use;
- advertised only to the medical profession;
- sold only through druggists.

PACKAGES:

Cerevim is sold in ½ and 1 lb. containers.

LEDERLE LABORATORIES, INC.
30 ROCKEFELLER PLAZA • NEW YORK, N. Y.



KARO FORMULAS FOR PREMATURE AND DEBILITATED INFANTS

DILUTE MIXTURES

Evaporated milk. 4 ozs.
Water, boiled. 12 ozs.
Karo. 1 tbs.
2 ozs. every 3 hrs. for 8 feedings

Lactic Acid milk (dried) 5 tbs.
Water, boiled. 16 ozs.
Karo. 1½ tbs.
2 ozs. every 3 hrs. for 8 feedings

CONCENTRATED MIXTURES

Breast milk. 12 ozs.
Evaporated milk. 4 ozs.
Karo. 1 tbs.
2 ozs. every 3 hrs. for 8 feedings

Lactic Acid milk (2%) . . 16 ozs.
Karo. 2 tbs.
2 ozs. every 3 hrs. for 8 feedings

FEEDING PROGRESS

Days of Age	Drams at Each Feeding	Ounces of Feeding per 24 Hrs.
1	1	1
2	2	2
3	4	4
4	6	6
5	8	8
6	10	10
7	12	12

(8 drams = 1 ounce)

Prematures usually thrive on Karo formulas



MOST of the common milk mixtures have been used at various times with some degree of success—evaporated, acid and dried milks, and butter-flour mixtures. Those high in protein and carbohydrate and low in fat are the most suitable in concentrated formulas properly adapted to the limited digestive capacity of the premature. While lactic-acid milk with addition of 7 to 10 per cent by volume of Karo syrup yields twenty-five to thirty calories per ounce, evaporated milk with 5 to 10 per cent added Karo syrup is equally effective.

Processed or acid milks are advantageous because of the fine curds produced, the premature being particularly susceptible to curd indigestion. Nonfermentable carbohydrate in quantities similar to those used in normal feeding of infants may be added to any of these milks. The formula may be concentrated by decreasing the water, or adding powdered protein milk in place of extra amounts of sugar."

KUGELMASS: "Newer Nutrition in Pediatric Practice."

CORN PRODUCTS SALES COMPANY

17 Battery Place, New York City



EYE PHYSICIAN GUILD OPTICIAN

When it comes to the treatment, examination and refraction of the eye, the professional knowledge and skill of the Eye Physician is essential.

The services of the GUILD OPTICIAN is the natural extension of the painstaking work of the Eye Physician.

Both are necessary for your patient's welfare.



Guild of Prescription Opticians of New Jersey, Inc.

EYE PHYSICIANS: Your prescriptions for glasses are "Safe" when referred to a Guild Optician.

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J. C. REISS
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CHARLES STEIGLER
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ANSBACH BROS.
212 Bassett Building

H. C. DEUCHLER
344 Springfield Ave.

WESTFIELD
BRUNNER'S
206 Broad St.

SPECIALTY

Knowing how to get things done has been this country's specialty. The men and women associated with Eli Lilly and Company have the habit of constantly improving products, facilities, and operations in all departments of the business. On this happy faculty depends the excellence of Lilly products.

FOR PROLONGED EFFECT Protamine, Zinc & Iletin (Insulin, Lilly)



The outstanding advantage of Protamine, Zinc & Iletin (Insulin, Lilly) is its prolonged blood-sugar-lowering effect, lasting at least twenty-four hours. Use of Protamine Zinc Insulin in selected cases of diabetes permits a reduction in the number of injections required daily and corrects the nocturnal hyperglycemia common in severe cases, thus bringing patients another step closer to normal living.

ELI LILLY AND COMPANY

Principal Offices and Laboratories, Indianapolis, Indiana, U. S. A.

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

PUBLISHED MONTHLY SINCE SEPTEMBER, 1904
Whole Number of Issues, 445

UNDER THE
DIRECTION OF THE
COMMITTEE ON PUBLICATION



HENRY C. BARKHORN, M.D., Chairman

HENRY A. DAVIDSON, M.D., Editor

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EXECUTIVE OFFICER—LEROY A. WILKES, M.D.
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Each member of the State Society is entitled to receive a copy of THE JOURNAL every month.

VOL. XXXVIII, No. 9

SEPTEMBER, 1941

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Single Copies, 30 Cents

MESSAGE FROM THE PRESIDENT

In 1932, when the report of the Committee on the Cost of Medical Care was released, The Medical Society of New Jersey departed from its time-honored principle of devoting itself, largely, to the field of scientific endeavor and embarked upon an intensive study of medical economics. Up to that time extra-professional activities had been confined, largely, to legislative efforts directed toward the maintenance of the highest possible standards of quality in the practice of the healing art. Since then we have been concerned with the protection of the democratic practice of medicine, while attempting to meet the growing demand for new methods of distribution of medical care.

Much has happened during these past nine years. Research by many foundations, the National Health Conference, a survey by the United States Department of Health and many other nation-wide activities have made it apparent that not

only many lay groups but also the Government of the United States are determined upon *regimentation* as the means of procuring improved methods of distribution of medical care. Your organization has been fully alive to this threat to the American way of the practice of medicine—a way that has produced a quality of medical care that stands out as preeminent. Committees have been actively studying every phase of the problem; hospital and dispensary surveys

have been conducted; group methods and insurance plans, the world over, have been investigated; and the New Jersey Health Conference, instigated by Governor Moore, was actively participated in. The combined net data obtained from all these activities have resulted in the conclusion that there is need for new methods of distribution of medical care; that medical service to the indigent is badly in need of improvement; and that the low income, and even the middle income

**FOURTH ANNUAL
FALL CLINICAL CONFERENCE**
December 3, 1941
ELIZABETH, NEW JERSEY
HOST: UNION COUNTY MEDICAL SOCIETY

groups must have new means of obtaining the best type of medical service, not as a charity but as a purchasable commodity. Whenever, in the past, there has been a great need for reform, that reform sooner or later has been effected. We are faced with a demand for changes in the economic side of the practice of medicine. The only question remaining to be answered is whether the doctor will meet this challenge and promote the necessary readjustments or whether he will stand idly by and have innovations forced upon him by lay groups or by legislation.

The Medical Service Administration is an outgrowth of the combined studies of all your committees during the past nine years. Its purpose is to demonstrate that the medical profession can solve many of the problems involved without destruction of the American way of the practice of medicine, preserving physician-patient relationship and free choice. By Act of the Legislature, this organization is the only agency in the State of New Jersey legally permitted to provide non-profit sickness insurance. This act legalizes two distinct types of service: (1) Non-profit sickness insurance, and (2) the authority to administer sickness insurance for any governmental or other authorized agency. Under the second provision, the Farm Security Plan for Medical Services is now being administered. Very shortly Plan II will be in operation. This provides for payment for medical and surgical treatment of patients who are hospitalized. It is anticipated that policies for this type of service will be sold in conjunction with policies of the Hospital Service Plan of New Jersey.

The criticism has been voiced that this will benefit only those physicians who have hospital privileges. While this may be true, it does in no wise work to the detriment of the physician who has no hospital connection. All inclusive sickness insurance is the ultimate objective of the Medical Service Administration. However, the first effort must be to es-

tablish confidence in, and prove the effective operability of this new organization. In any insurance undertaking reliable actuarial data are essential for success. At the present moment no actuarial data are available for all-inclusive sickness insurance, whereas such data are at hand for cases requiring hospital care. This fact makes possible the writing of policies for payment of medical and surgical fees in hospitalized cases on an actuarially sound basis. It is estimated that enough policies of the kind, for which there is a great demand, can be sold to make the Medical Service Administration a self-supporting agency. Once this has been accomplished, it will be possible to experiment with and, gradually to put into operation sickness insurance plans of an all-inclusive nature for medium and lower income groups. The caution being displayed is for the welfare of every practicing physician, since failure in this project will be to the everlasting detriment of organized medicine. The success of the administration of sickness insurance, such as the Farm Security Plan, will make possible, for the future, the operation of other governmental services to special groups in such a way that free choice and the independent practice of medicine will be preserved while, at the same time, government will be satisfied as to the adequacy of medical care to those special groups in which it is interested.

The Medical Service Administration is the best organization of its kind in the United States. While the Administration is a separate corporation, it is under the control of The Medical Society of New Jersey, in that its Board of Governors must be appointed annually only after approval by the Trustees of The Medical Society of New Jersey. No new service may be undertaken by the Administration until it has been sanctioned by our Trustees and no policies will be sold nor will any service be propagated in any county until the Medical Society of that county shall have given approval. Here,

then, is an agency devised for the sole purpose of meeting the present-day demands for new methods of distribution of medical care in such a way that the welfare of the individual practitioner can be protected by his State and county organizations. It can succeed and it must

succeed. The wholehearted support of every member of The Medical Society of New Jersey will assure that success.

THOMAS K. LEWIS, M.D.,
President,
The Medical Society of
New Jersey.

DR. OR M.D.?

With every gymnast, music teacher, philosopher, and cultist calling himself "Doctor", it is no wonder that the public is becoming increasingly confused. Not only do correspondence school alumni with a yen for ornamentation use the "Doctor" label, but many respectable citizens, like dentists and clergymen, have a legitimate claim to the title, too. It seems that the physician's best way of clearing out the fog is to exhibit the distinguishing "M.D." on his sign, letterhead, prescription blank and phone book. Eventually it will bite into public consciousness. In fact, it is even possible to stress "M.D." in speech. Thus, we ask a

patient: "Were these eyeglasses prescribed by a physician?" He answers yes because he thinks that the optometrist is an "eye physician", but were we to ask if the glasses were prescribed by an M.D., the patient would get the point promptly.

While physicians may resent the growing dilution of the title "doctor", let it be remembered that the label was never our exclusive property anyway. On the other hand, "M.D.", that unmistakable touchstone of the doctor of medicine, is the insignia of a hard-earned professional status. It is a good point to remember for the next order for check books or stationery.

THE UNFILLABLE PRESCRIPTION

The present experimental status of sulfadiazine lights up the confusion now existing about the availability of many new drugs. Under Federal Drug Regulations no new medication may be offered for sale until the manufacturer has filed an application with the Food and Drug Administration, supporting this with proof of the product's therapeutic value and proof of its safety. If this evidence is satisfactory and the competence of the clinical experts acceptable and if the Food and Drug Administration interposes no objection within sixty days, manufacture and general distribution may begin.

During this trial period none of the drug is available for general prescription use, but supplies for clinical trial are fur-

nished by the manufacturers to clinicians of choice and to other qualified medical experts who may make direct application to the manufacturer. The composite findings of this group of observers determine the value, if any, of the proposed new drug. As their results are reported in discussions or in printed reports, medical interest in the new product increases, especially if the reports are favorable. When the general practitioner listens to a laudatory address or reads a convincing report of the value of a new drug his impulse is to give his own patients the benefit of the new medication. Assuming the general availability of the drug, he writes a prescription for it. His patient sallies forth to have the prescription compounded and is met with the startling

and embarrassing explanation that the prescription cannot be filled because the drug is not available for that purpose. Not convinced by his first failure, the patient travels from drug store to drug store with no better success. Convinced of the futility of his quest, he returns for explanation to the doctor who, in all good faith, prescribed a medicine that was not obtainable. This embarrassing situation has arisen time and again throughout the nation ever since the clinical trial period for new drugs was made mandatory.

While these complications are brought about primarily by the regulations which govern the introduction of new drugs, no fault should be found there because the sole and wholesome purpose of the Food and Drug Administration is to safeguard the health of the American public. No good citizen can object to that.

Chief responsibility for the confusion seems to lie with the manufacturer. He can prevent misunderstanding by stating clearly to the clinicians selected to test its value and safety, that the new drug is available for experimental use only and that during the experimental period, it cannot be obtained except by direct application to the manufacturer. He should request that this be clearly stressed in all the reports of the experimenting clinicians. When a medical journal is asked to publish a report of favorable clinical results with a new drug, the journal should be informed if the preparation is not available for general prescription use.

Abstracted from the *Weekly Roster and Medical Digest* (Philadelphia) at the request of the N. J. Committee on Pharmaceutical Problems, C. I. Ulmer, M.D., Chairman.

DOCTORS, DEFENSE AND BUREAUCRACY

Under the title "The New Disease", the National Physicians' Committee has released a timely warning against "the stifling control of bureaucracy", which this Committee fears may attach itself to the country during the defense emergency, and which may hang on long after the emergency will have passed. The Committee suggests that this feeling of security in bureaucratic definiteness is part of a war hysteria which they dub "The New Disease". To quote the opening paragraphs of their release:

"American physicians must prepare to cope with a new disease. It is contagious and attacks all without discrimination. Doctors are especially susceptible to the contagion. Until it is better named, the new disease can be called 'War Fever'. The future status of the American doctor will be determined by the extent to which individual physicians are successful in immunizing themselves against the hysteria."

It is unquestionably true that in times of great national emergency, any central government finds its powers enormously enhanced. We all remember the governmental regulation of food, newspaper releases, railroads, liquor traffic, gasoline consumption, etc., during the War of 1917-18. It would be easy during the present crisis to assert that the health of the people was so important a determinant of defense, that only centralized government control of health resources could meet the needs. Such a thesis sounds convincing. For instance, it might be argued that the rehabilitation of defects in potential soldiers is a government duty; that the prevention of epidemics in areas to which large masses of civilians might be evacuated is also a governmental function. Using this as a springboard the next step would be to demand state regulation of medical practice—just as a "temporary" or "emergency" measure of course. But it is written in the history

of politics that no established state agency ever wants to commit suicide, and that government officials and government employees have a perfectly natural desire to perpetuate their jobs and functions. Under the circumstances, there is real danger that a straight-jacketing of medical practice, first justified on the grounds of "National Defense" or "Public Emer-

gency" may etch its way into the pattern of American medicine.

The American physician today enjoys a unique freedom from officious tampering. The health center for most individuals is still the private doctor's office, not City Hall. This freedom is worth preserving. And we all know that the price of liberty is eternal vigilance.

"THE AMERICAN WAY"

Next month The Medical Society of New Jersey will participate in one of its largest and, we hope, most effective public relations projects. During the week of October 6, members of this society will speak to some 85 Kiwanis Clubs in New Jersey, addressing them on "The American Way of Distributing Medical Care". It is expected that our total audience will exceed 3000. Since, as is well known, members of the Kiwanis Clubs are usually prominent business and professional men, the project constitutes a rare opportunity for Organized Medicine in this state to acquaint an important segment of the public with its philosophy. And since, especially in smaller communities, these meetings are reported in detail in local newspapers, the audience reached by these talks will extend far beyond the attendance at the meetings.

The subject "The American Way" was chosen by the Kiwanis. In recognizing that our system of unregimented, individualized medical practice is in the true tradition of the American Way, the Kiwanis have put their fingers on one of the strengths of the position consistently taken by Organized Medicine. It is to be noted that our Society's presentation is only one in a series of talks being given to the Kiwanis during 1941. They have heard other professions—journalists, educators, labor union officials, clergymen—present their respective attitudes in terms of our American culture. Thus, from the viewpoint of the audience, the year's program is a mosaic of many disciplines,

each with its own problems and its own philosophy, but together integrating to form the American pattern of life.

From the viewpoint of The Medical Society of New Jersey this program offers at once a unique opportunity for a much-needed presentation of the case of Organized Medicine, and a test of the willingness of the members to take the time, trouble and effort required if this project is to be successful. Obviously the job of delivering 85 speeches in one week can not be carried out by a handful of officers: it requires the active participation of dozens of members. And those of us who are not participating in the actual speaking can help by telling friends and patients about the project, by encouraging Kiwanis whom they know to attend these meetings, by looking up and publicizing the newspaper accounts of the talks, and by taking part in a subsequent evaluation of the success of the project.

It has been said with monotonous frequency that Organized Medicine has a bad press. If it has, it is because of the loudness of our critics compared with the inarticulateness of most doctors. But here is a chance to reach for something of a balance, in the one-sided battle of words. Here is a ready-made sounding board and a huge forum. This is our turn at bat. It is a magnificent opportunity. Let us make the most of it.

PUBLIC RELATIONS COMMITTEE,
MEDICAL SOCIETY OF NEW JERSEY.

ORIGINAL ARTICLES

TREATMENT OF RICKETS WITH A SINGLE MASSIVE DOSE OF
VITAMIN D

By ISRAEL J. WOLF, M.D., Paterson, N. J.

This paper won the prize awarded in the Medical Society's 1941 contest and was read at the Annual Meeting in Atlantic City, May 21, 1941.

Despite the widespread use of vitamin D preparations, many infants receive inadequate prophylactic treatment and develop rickets. In poor families, infants may be examined too infrequently to detect the disease in its incipency. Many mothers discontinue cod-liver oil or the concentrates with the slightest intestinal upset or rash, conditions usually due to some other cause. These preparations are too often omitted during the summer months even when the infant is protected from the sun. Infants receiving breast milk will develop rickets if the mother's diet lacks sufficient vitamin D.

During the past year I collected five cases of marked rickets in infants in hospital practice. Each of these I treated with a single massive dose of vitamin D.

HISTORICAL BACKGROUND

Although the name of Glisson is associated with the classic description of rickets, others certainly preceded him in describing this affection. One of the earliest descriptions is that of Daniel Whistler¹ in 1645. Not until 1921, however, was it recognized (by Mellanby) as a deficiency disease.

For the cure of rickets, cod-liver oil was the time-honored remedy. In 1922 Zucker² and his colleagues showed that the active principle of cod-liver oil was contained in the ether soluble unsaponifiable fraction of the oil and was similar in its solubilities to cholesterol. He was able to concentrate it so that it possessed many hundred times its original potency.

Ergosterol was first known in 1811, but not until 1924 was the possibility of its activation discovered. Today there are two different methods of activation, one by ultraviolet irradiation, the other by bombardment with low velocity electrons.

At least ten forms of vitamin D are now known, but only two have practical importance. One is activated ergosterol of plant origin, in its pure form known as "calciferol" and given the name of "viosterol" by the Council on Pharmacy and Chemistry; the other³ is activated 7-dehydrocholesterol, of animal origin.

RAPID HEALING OF RICKETS

Doses of vitamin D which will prevent rickets will also heal it, but often too slowly. If rickets exists it is best to cure it rapidly. In 1928, Vollmer⁴ reported that it was possible to prevent and cure rickets in rats with one single subcutaneous or mouth dose of 1 mg. irradiated ergosterol. This is more than a thousand times the effective single daily dose. He also treated six rachitic infants with irradiated ergosterol, 14 to 24 times the effective dose (instead of 1,000 times as in rats), divided into several doses, administered subcutaneously as well as orally. The rickets was cured but the speed of healing was not satisfactory.

Since the earlier preparations of vitamin D contained toxic by-products, like toxisterol, it was not possible to increase the dose until several years later when Windaus and Holz were able to produce a purer vitamin D preparation now known as "calciferol" or "viosterol".

Between 1928 and 1938 numerous authors, principally in Germany, reported more than 160 cases of rickets and tetany treated with a

1. Major, Ralph H.: *Classic Descriptions of Disease*. Charles C. Thomas, Springfield, Ill. 1932.

2. Zucker, T. F.; Pappenheimer, A. M., and Barnett, M.: *Proc. Soc. Exper. Biol. and Med.*, 19:167 (1922).

3. Bills, C. E.: Quoted by Park, citation 7 below.

4. Vollmer, H.: *Treatment of Rickets and Tetany with Single Dose of Vitamin D*. *Journ. Pediat.*, 14:491 (Apr., 1939).

single massive dose of vitamin D varying between 10,000 and 600,000 units without damaging results. The results have ranged from slow or unsatisfactory healing to accelerated permanent healing depending on the dosage. Lower dosages gave poorer results.

Vollmer⁴ found it necessary to give infants six months or older 600,000 units or more in order to get good results. In a few days a marked clinical change occurs in these infants, and the serum calcium and phosphorus reach normal levels. Calcification begins in about 12 days and is complete in 40 days.

REPORT OF CASES

CASE 1

Paul Y., aged 5 months, colored, was admitted to the Barnert Hospital April 6, 1940. He was subject to colds, suffered from anorexia, restlessness and fitful crying of recent origin. Though fed on the breast, with complementary feedings, he received no cod-liver oil or fruit juice. He weighed 15 pounds, showed beading of the ribs, craniotabes and knobbing of the wrists.

Laboratory Data.—The Wassermann test was negative; urinalysis showed a faint trace of sugar and acetone. The serum calcium and phosphorus determinations were as follows:

Date	Calcium (Normal 10 mg.%)	Phosphorus (Normal 4-5 mg.%)
April 12, 1940	10 mg. %	0.9 mg. %
April 27, 1940	11.6	5.2

Treatment.—Ertron, 600,000 units, was administered in two divided doses by gavage in the formula on April 12, after blood for calcium and phosphorus determinations had been taken.

Roentgenograms.—On April 6, 1940, roentgenograms of the upper and lower extremities showed active rickets.

April 24, twelve days after ertron was given, a deposit of calcium was seen at the metaphyses.

May 18, showed the rickets healing.

September 1, four and one-half months after ertron was administered, the rickets was fully healed. Patient did not return for interval roentgenograms following discharge.

CASE 2

Herbert S., aged 5 months, colored, was admitted to the Barnert Hospital May 8, 1940, with a history of cough for one week, vomiting for three days, loose stools and excoriated buttocks. His birth weight was 6 pounds and 12 ounces. He was breast-fed for three months, received one teaspoonful of cod-liver oil daily for one month and four ounces of orange juice daily for a month. He weighed 11 pounds and 2 ounces; he showed an angular type of beading, mild bilateral craniotabes and a profuse muco-purulent nasal discharge.

Laboratory Data.—The Wassermann test was negative. The urine showed a trace of albumin and sugar. A hemoglobin (Sahli) was 62 per cent, the white blood cells 7,800 with 68 per cent lymphocytes and 32 per cent polymorphonuclear cells. The serum calcium and phosphorus determinations were as follows:

Date	Calcium	Phosphorus
May 15, 1940	10.7 mg. %	3.2 mg. %
June 3, 1940	10.2	3.9

Treatment.—Treatment with vitamin D was delayed to rule out scurvy. Ertron was given on May 27, 600,000 units in two divided doses in the formula.

Roentgenograms.—Roentgenograms on May 9, 1940, showed active rickets in the upper and lower extremities.

On May 27, the rachitic process was unchanged. Ertron was given on this day.

June 6, ten days after administration of ertron, calcium deposition was seen at the metaphyses. No subsequent films were taken as patient did not return for follow-up after discharge June 7, 1940.

CASE 3

Irene V., aged 18 months, colored, was admitted to the Barnert Hospital July 2, 1940. She was unable to walk properly although she waddled occasionally with feet everted. Indeterminate amounts of cod-liver oil had been given at the age of two months and continued through the winter. She weighed 23 pounds. There was beading of the ribs, knobbing at the wrists and external rotation and anterior bowing of the legs.

Laboratory Data.—The Wassermann test was negative; urinalysis was negative; the hemoglobin (Sahli) was 55 per cent, the white blood cells 7,200 with 60 per cent lymphocytes and 40 per cent polymorphonuclear cells. The serum calcium and phosphorus determinations were as follows:

Date	Calcium	Phosphorus
July 3, 1940	12 mg. %	2 mg. %
July 15, 1940	11.6	4.1
August 2, 1940	13.7	3.0
August 16, 1940	10.0	3.3

Treatment.—600,000 units of ertron were administered on July 10, 1940. This was given in Pabulum in two divided doses.

Roentgenograms.—Roentgenograms on July 2 and 10, 1940, showed marked active generalized rickets (Fig. 1).

July 29, three weeks after ertron was given, marked deposition of calcium was seen at the metaphyses (Fig. 2).

August 29, practically complete healing of rickets. Lower extremities normal; metaphyses of upper extremities show some irregularity of calcified margins.

September 28, healing entirely complete, although healing might have been considered completed at last examination or roughly in six or seven weeks (Fig. 3).

CASE 4

Alphus R., aged 14 months, colored, was admitted to the surgical service of Dr. Spickers on September 23, 1940, with a fracture in the middle portion of the right femur. The fragments were in good alignment as shown by roentgenogram, and a cast was applied. On October 7 the pediatric department was consulted because the infant had developed a diarrhea. He had signs of active rickets, knobbing of the wrists and beading of the ribs. This was confirmed by roentgenogram.

The patient was discharged on October 29 and readmitted on November 2 because his cast was off. On roentgenogram there was angulation at the side of fracture with callus formation and the periosteum was raised considerably on either side of the fracture site. A cast was reapplied.



FIGURE 1

Irene V., July 3, 1940—active rickets shown at wrist. (Case 3.)

Laboratory Data.—The Wassermann test was negative. The urine showed a two-plus acetone reaction. The serum calcium and phosphorus determinations were as follows:

Date	Calcium	Phosphorus
Oct. 9, 1940	9.5 mg. %	3.1 mg. %
Oct. 18, 1940	12.0	3.2

Treatment.—600,000 units of ertron were administered in two divided doses on October 14, 1940.

Roentgenograms.—A roentgenogram on October 7, 1940, showed generalized rickets at the ends of the long bones and a generalized periostitis.

October 25, eleven days after ertron was administered, distinct calcification at the lower ends of long bones of the upper and lower extremities was seen.

November 11, calcification more dense.

November 29 the ends of radius and ulna assuming normal appearance. Rickets may be considered healed about six weeks after administration of ertron. Periostitis still present.

December 18, rickets in lower extremities completely healed.

December 24, rickets in upper extremities completely healed.

CASE 5

Angelo La P., aged 16 months, white, was admitted to the Barnert Hospital March 10, 1941. He



FIGURE 2

Irene V., July 29, 1940, three weeks after ertron—marked deposition of calcium at metaphyses. (Case 3.)

had been sick with cough and fever for five days. An admission diagnosis of lobar pneumonia was made. The infant's weight was 18 pounds and he was dehydrated. His dehydration was treated and he was given sulfathiazole. On March 16 a diagnosis of empyema was made, and on tap, 75 cubic centimeters of purulent fluid were withdrawn. Intercostal drainage was performed on March 18. Two citrated blood transfusions were given during the first week in the hospital. An admission diagnosis of active rickets was also made. This infant had received no cod-liver oil.

Laboratory Data.—The Wassermann test was

negative. The hemoglobin (Sahli) on March 20 was 58 per cent, the white blood cells were 11,350 with 43 per cent lymphocytes and 57 per cent polymorphonuclears. The empyema fluid contained type 4 pneumococci. The serum calcium and phosphorus determinations were as follows:

Date	Calcium	Phosphorus
March 8, 1941	8.0 mg. %	.....
March 21, 1941 .....	.....	3.0 mg. %
April 9, 1941	13.0	3.9

Treatment for Rickets.—The patient was given 100 mg. cevitic acid daily and full therapeutic doses of vitamin B complex. Ertron was not administered until March 22 to rule out a scorbutic process. 600,000 units of ertron was given in two divided doses in Pabulum.

Roentgenograms.—A roentgenogram taken on March 14 showed active rickets at ends of the femora, the lower ends of the tibiae, fibulae, radii and ulnae. This condition was unchanged following the administration of vitamin C.

March 31, nine days after the administration of ertron, calcification was seen at the lower ends of the radii and ulnae and the lower ends of the femora.

On April 7 sixteen days after ertron was given, the healing of the rachitic process was well advanced; it was more pronounced in the lower than the upper extremities.

COMMENT

Five cases of active rickets in infants between the ages of five and eighteen months were observed. Four of these cases occurred in Negroes and the fifth was of Italian parentage. None of these infants had received sufficient vitamin D to prevent rickets. I treated each of these patients with a single massive dose of vitamin D to produce rapid healing as outlined by Vollmer.⁴ I used a preparation called ertron, which he suggested, which is a form of ergosterol activated by electrical discharges instead of by ultraviolet irradiation. The official name for this form of vitamin D is "calciferol" or "viosterol". It is of vegetable origin, whereas activated cholesterol is of animal origin.

Ertron is marketed in capsules of 50,000 units each. Six capsules, or 300,000 units, are opened and the powder is mixed with the formula or Pabulum. Two feedings are given, or a total dosage of 600,000 units. Our first infant was gavaged but this proved unnecessary as the other infants took the ertron readily without gastric upset or diarrhea. No toxic

symptoms were observed; on the contrary, those infants who suffered from irritability and lack of well-being as a result of the rickets showed a remarkable change in their condition within a few days.

The clinical diagnosis of rickets was supported by roentgenograms and the blood chemistry. Normally the concentration of calcium in the blood serum in infants is about 10 mg. per cent. Elliot and Park⁵ state that in infantile rickets the calcium usually remains normal although it sometimes is diminished. The inorganic phosphorus is reduced in rickets, usually to between 2 and 4 mg. per cent, sometimes



FIGURE 3

Irene V.—Roentgenogram taken on September 26, 1940 shows healed rickets. Process was healed, however, between the sixth and seventh week. (Case 3.)

lower. In our first case the phosphorus was 0.9 mg. per cent before treatment and 5.2 mg. per cent two weeks after ertron was given. In the other cases the phosphorus was 2 or 3 mg. per cent prior to treatment and rose after

5. Elliot, M. M., and Park, E. A.: Rickets; Chapter 36 of *Practice of Pediatrics*. Joseph Brennehan. W. F. Prior Co., Hagerstown, Md. 1940.

treatment. The serum calcium ranged between 8.0 and 12.0 mg. per cent prior to ertron and rose as high as 13.7 mg. per cent after ertron was administered.

Park⁷ states that if smaller doses of vitamin D (1200 units or more) are given in the ordinary case of rickets, the first indication of a therapeutic effect will be a rise in the level of inorganic phosphorus in the serum. This begins about ten days after treatment is initiated. About three weeks after treatment is begun, the shadows of fresh lime salt deposits make their appearance in the x-ray films. As treatment continues this deposition becomes heavier and the filling-in process may take two months or longer.

If larger doses of vitamin D are given this process is accelerated. In the two cases in which we did a serum phosphorus determination on the fifth day after ertron was given, the phosphorus was already considerably elevated, usually the lower level of normal. Roentgenograms taken as early as the ninth to the twelfth day after ertron was given usually showed considerable calcium deposition. Healing was hastened so that it was usually complete in six or seven weeks (see figures 1-3).

ADVANTAGES

Administration of a single massive dose of vitamin D offers numerous advantages in the treatment of rickets. A preparation such as ertron is easily given, well tolerated and causes no toxic or ill effects. The hospital stay may be greatly shortened if the patient presents no other problem. Treatment may be carried out

in the out-patient department with the assurance that the necessary dose of vitamin D has been given to produce a cure and without further thought concerning the problem of administration.

If the patient suffers from a severe debilitating infection, such as in our case of empyema, there is a great advantage in bringing about a rapid cure of the rachitic process. If the chest wall is soft, or the child active, rapid calcification of the bones lessens the danger of deformity. The rapidity of the results also makes this treatment useful in neonatal and infantile tetany. A single massive dose of vitamin D restores the serum calcium rapidly to normal even without calcium administration.

Vollmer⁶ has shown that vitamin D administered in a single massive dose is stored in the liver, skin and brain tissue.

SUMMARY

Five cases of active rickets in infants between the ages of five and eighteen months were treated with a single massive dose (600,000 units) of vitamin D in the form of ertron, which is ergosterol activated by electrical discharges in a low pressure chamber. This treatment brings about a rapid therapeutic improvement in the patient clinically, serologically and roentgenographically. No ill effects were observed. The advantages offered are curtailment of hospital stay, accuracy of administration and an early cure—which is desirable in infants suffering from severe rickets or associated debilitating infections. Rapid results are also obtained in neonatal or infantile tetany. The general practitioner may well add this proved method of therapy to his armamentarium.

6. Vollmer, H.: Distribution of Vitamin D in the Body. *Amer. Journ. Dis. Childr.*, 57:343 (Febr.) 1939.

7. Park, E. A.: *The Vitamins*, by Gordon and Severinghaus. *Amer. Med. Ass'n, Chicago*. 1939.

THE LEGAL RESPONSIBILITY OF THE PHYSICIAN WITH SPECIAL REFERENCE TO PHYSICAL THERAPY

JOSEPH RUBACKY, M.D., L.L.B., Passaic, N. J.

Read before the N. J. Society of Physical Therapy Physicians on February 27, 1941.

The addition of physical therapy equipment to the armamentarium of the practicing physician has increased the legal obligations imposed upon the treating physician and others who prescribe such form of therapy.

As Granger¹ has suggested: "It is an abuse of physical therapeutics to use it except: (1) after a careful physical and laboratory examination; (2) as an adjunct to other standard and well-recognized procedures; (3) in teamwork with other branches of medicine and surgery; (4) after a definite attempt is made to apply proper physiological effects to the predetermined pathological condition; and (5) when every care is taken not to use it in place of other proved methods that may be superior."

To this we may add the opinion of Kovacs,² who has stated that the operator of apparatus must have a fair concept of its working mechanism and full knowledge of the technic of its application. As a rule, such knowledge must be acquired on the basis of clinical instruction and experience, and not from salesmen of the equipment. The doctor should be able to visualize what is going on inside the apparatus after it is started, how the energy output is controlled and how it will affect the parts of the body subject to its influence. He must know how to apply and hold the electrodes in good position and proceed without discomfort to the patient, to the degree of maximum efficiency. He must be familiar with the danger signals of chemical or heat burns. He must take nothing for granted, so far as the patient is concerned, and use all reasonable precautions to avoid accidents,³ save for willful acts or neglect of the patient in disregarding intelligent warnings. No complaint of a patient during examination or treatment, no matter how trivial, should ever be brushed aside.

Not only must the diagnostician be versed in his art, but he must understand physics and chemistry, as well as anatomy and physiology.

In addition, he must employ competent aids and direct and supervise his assistants, nurses or technicians so that he shall not become liable for injuries arising from otherwise well prescribed treatments.

THE PHYSICIAN'S LIABILITY

What then, is the liability of the physician for injuries sustained by a patient? To answer this, we must first learn the duty a physician owes to his patient, because it is only for a breach of this duty that he can be held legally accountable. The duty of a physician to his patient has been defined by our courts, which hold that the responsibility of a physician is not to cure the patient, nor is the doctor a guarantor or an insurer that his treatment will be successful, but rather, that he will treat the injury he is employed to treat with ordinary care, diligence and skill. This means that his obligation requires only that he shall exercise such a degree of care, skill and diligence as physicians and surgeons, practicing in the general neighborhood and pursuing the same line of practice, ordinarily employ in like cases. For example, he is not liable for malpractice because of an unfortunate result, nor is he liable for having used some particular method in the treatment of his patient, the courts having held that where, among physicians of ordinary skill and learning, more than one method of treatment is recognized as proper, a choice of one treatment as against the other is not an act of negligence. The fact that another physician would have used a different method in a particular case is not proof of negligence.⁴ We all know that in times of emergency, a physician must act with great speed, and the courts, cognizant of this fact, also hold that where he is free from negligence he is not

1. Granger, F. B.: Use and Abuse of Physical Therapeutics. *Jour. A. M. A.*, Oct. 8, 1927, Vol. 88.
2. Kovacs, Richard: Accidental Injuries in Office Practice. *Jour. A. M. A.*, Jan. 14, 1933, Vol. 100.
3. Haring et al. vs. Bank (N. J.) 146 Atl. R. 675.
4. Gramaldi vs. Zeglio et al. (N. J.) 129 Atl. R. 475.

liable for injuries arising from honest errors of judgment.⁵

While the law does not exact the impossible, it will not tolerate ignorance, carelessness or experimentation. The controlling question and the standard by which negligence must be determined is, "did the defendant use that degree of care, skill and learning as a physician and surgeon, practicing in the same locality and pursuing the same general line of practice, would ordinarily have employed under like circumstances?" The failure to possess or use such skill and care as is required and allegations that the injuries complained of were brought about thereby cannot be supported on mere theory, conjecture or inference, but must be based on tangible, substantial evidence which the court and jury may grasp and understand.⁶ For this reason, proof of negligence must appear from expert testimony and such testimony must show that the wrong averred was a direct result of the negligence pleaded. There is one exception to this rule; viz., that expert testimony is not required for proof of matters of common knowledge or things and facts which do not require special training or learning.⁷

The standard of care, skill, and diligence required of a physician in general practice is not fixed by the dictum of an expert, but by the care, skill, and diligence ordinarily possessed and exercised by others in the same line of practice and work in similar localities.⁸

On the other hand, though a specialist is held to the exercise of skill and possession of more knowledge than a general practitioner, he is not held to the exercise of a special degree of care, but only to ordinary care under all of the circumstances of the case.⁹

THE NURSE OR TECHNICIAN

What is the status of the physician who employs nurses or assistants, particularly when

he is engaged in the practice of physical therapy? Because electricity is regarded as a dangerous instrumentality with the ever-present capacity to do serious bodily harm unless restrained within proper limitation, it is essential that its use as applied to the human body should be under the direction of authorized persons.¹⁰ Hence, agency cannot be delegated to a nurse by a physician without the consent of the patient who hires his services.¹¹ However, if the relation of a nurse to a physician is that of servant and master, he becomes responsible for her overt acts of commission or those of omission, under a legal theory known as "Respondeat Superior."¹²

This principle was applied by the N. J. Court of Errors and Appeals in *Cappell vs. Jones*, 136 Atl. R. 390. A nurse was employed by a physician to render an electrical treatment. While left unattended, the patient received a burn. Litigation followed, which resulted in a judgment favorable to the defendant. On appeal, however, our learned judges decided that negligence could reasonably be inferred and, therefore, a fact question arose which became a matter for a jury to determine. In the light of what we have just learned with respect to the necessity of expert testimony to prove and establish negligence and the liability of a physician, this seems rather startling. The only facts in the case were that the electrical apparatus was used in the treatment of the patient, the patient was left unattended and was burned. There must be a greater duty owing by those who are engaged in the practice of physical therapy; and there is, because they employ, in their practice, machinery and instrumentalities which are in themselves dangerous. Courts have held that where a dangerous instrumentality is under the control and supervision of a person, the presumption is that, were it not for some negligence on his part, one would not have been injured thereby. This raises an inference of negligence, which does not necessarily mean that the physician is guilty of negligence, but merely that sufficient inference is raised to permit the case to be determined by a jury.

5. *Dunn vs. Beck* (Mont.) 260 Pac. R. 1047.

6. *Wright vs. Conway* (Wyo.) 241 Pac. R. 369.

7. *Seewald vs. Gentry* (Mo.) 286 S. W. R. 445; *Vergeldt vs. Hartzell* 1 Fed. (2nd) 635; *Evans vs. Roberts* (Iowa) 154 N. W. 926.

8. *Czapka vs. Sadowski* (Mich.) 219 N. W. 660.

9. *Beach vs. Chollett* (Ohio) 166 N. E. 145.

10. *State Board of Medical Examiners* (N. J.) vs. DeBaun 147 Atl. 744.

11. *Stawicki vs. Kelly* (N. J.) 113 N. J. L. 551.

12. *Van Steenburgh vs. Thornton*, 33 At. 380, 58 N. J. L. 160.

DEFECTIVE EQUIPMENT

Not only do the courts recognize apparatus used in physical therapy as dangerous instrumentalities, but we, who constantly render such treatments, should so regard them and use every care to see that our machines are free from defects. Absence of such care is gross negligence which can sometimes have serious results. Medical literature is replete with tragic accidents which have occurred in homes, private offices and institutions. Suffice it to mention but two cases reported by Kovacs² and Kowarschik.¹³

In one case, a physician attempted to demonstrate to a girl, 19 years of age, the mild heat effects of a high-frequency current by making her hold two cylindric metal electrodes. When the current was turned on, she fell dead. Investigation revealed that a broken wire in the transformer had caused the dangerous, high voltage, low frequency current to jump over into the high frequency circuit, there being, contrary to the safe rule, direct (galvanic) coupling between the two sides instead of a safe inductive or magnetic coupling. This accident could have been avoided by a casual inspection of the apparatus which was used.

In the second instance, galvanic treatment for facial paralysis was administered from a new type of vacuum tube generator, which changes the alternating street current into a direct or galvanic current. One electrode in the form of a half mask was placed over the face, the other over the forearm. A small, cheap circular wire rheostat, similar to the control on radio boards, was used to regulate the strength of the current. At the end of the treatment, the assistant slowly turned this control back to zero, and just at that moment, the patient cried aloud and fell unconscious to the floor as if struck by an electric bolt. The cause for the profound electrical shock was found in the poor construction of the rheostat, the lever of which had swung over from the zero position to 360 degrees—that of full strength—without an intervening catch. The patient thus suddenly received the full strength of the current through the head.

CONTRIBUTORY NEGLIGENCE

The layman is quick to assume that unfortunate results are caused by negligence or departure from properly approved practice. Seldom does he realize that the patient can contribute to his own misfortune and that were it not for his contributing negligence, the injury would not have occurred. Fortunately, the courts bar recovery where a patient has been guilty of negligence which has contributed to his own injury¹⁴ and legal decisions demonstrate that a “no cause for action” is returned by a jury after proof that the conduct of the patient contributed to his own damage. Many states even go so far as to hold that contributory negligence, no matter how slight, bars recovery from a physician.

SUMMARY

The following rules should be remembered by those using physical therapy equipment. From the medico-legal standpoint, they are the ten commandments of physical therapy.

1. Secure thorough didactic and practical knowledge of your specialty.
2. Select reliable apparatus and equipment.
3. Keep these in perfect mechanical condition.
4. Examine the patient or the part of the body to be treated carefully and thoroughly.
5. Choose the correct modality.
6. Employ qualified assistants or technicians.
7. Assure proper application of current or other physical agents to diseased or injured areas.
8. Maintain constant supervision of treatment recommended to determine tolerance and susceptibility.
9. Advise patient to report immediately any pain, distress, discomfort or unexpected heat or pricking sensation.
10. Reexamine (a) area treated for local reactions or (b) patient in toto for abnormal systemic reactions.

13. Kowarschik, Josef: Die Gefahren elektromedizinischer Apparate, *Ztschr. f.d. Phys. Therap.* 42:82-89, 1932.

14. *Phifer vs. Baker* (Wyo.) 244 Pac. R. 637.

Aside from the purpose of case history, it is essential that you keep and maintain accurate and complete records for your future protection and security against the vindictive. Months and years often pass before the unsuspecting doctor is cross-examined by counsel for the plaintiff. As he is being grilled in the witness chair his demeanor, poise and responses tend to create an impression on each juror. Hesitant

answers, as well as the too often repeated phrase "I do not remember" create an impression of carelessness which may strongly influence the jury. Therefore, refrain from depending entirely on memory. Resort to your patient's history and progress charts for details which will stamp your name indelibly in the court room as one who is meticulous, learned, and skillful.

57 Passaic Street

DISEASE IS OUR BUSINESS

"Medicine is not interested in war as war. It is the plaything of ambitious politicians. But disease is our business. We should know about that. If war comes to us, Medicine can and will provide capable medical officers to the armed forces; it has done this before; it can do so again. Wars come and go. But what of the disorders beneath? What of the social maladies? What of these things, these diseases, which have produced 'that bad man' with his ulcerous total war? Are you studying those diseases, physicians? Has Medicine sufficiently interested itself in these things? Has it contributed to their relief and cure? Sickness is the business of Medicine. These social maladies have not fallen upon us like a sudden epidemic of influenza. They have been with us for a long time.

"But because they did not break out with rashes or have vomiting spells or protruding eyeballs they were not recognized always; many did not and perhaps do not consider them to fall within the proper sphere of traditional medicine; but there they are, and they cannot

be wished away. Some of these diseases were mere ideas in their inception not so long ago, little ideas which, in an environment of want, loose thinking, and neglect, flourished in those areas of cities long ago abandoned by the medical schools. Some of those little ideas are now, with the passage of time, large ideologies. Are you studying them, physicians? You are no more immune from these social diseases than the rest of the population. They have grown, those diseases and the ideologies which were once little ideas, until they have crowded this nation to the very brink of war as the only remedy available; they have grown until they have reversed the whole current of our civilization, until 'we have on our hands today . . . a war without a definite prospect of peace' because 'the enemy does not recognize peace as we know it; and we ourselves cannot define it.'

"It appears to be imperative that Medicine should broaden its concept and study to include those diseases of society, those social disorders among which it must live and move and have its being. To neglect this study is to invite oblivion."—N. Y. State Journal of Medicine.

TWENTY YEARS' EXPERIENCE IN THE TREATMENT OF CARCINOMA OF THE UTERINE CERVIX AND BREAST WITH RADIUM

By EDGAR A. ILL, M.D., Newark, N. J.

Read before the Section on Radiology of the Annual Meeting of The Medical Society of New Jersey,
in Atlantic City, June 5, 1940.

On June 6, 1924, I presented before The Medical Society of New Jersey a paper on the treatment of cancer of the uterine cervix, with radium. My interest in this subject was stimulated by personal contact with Dr. John G. Clark, of Philadelphia, who at that time reported some very encouraging results which he had had with the treatment of cancer of the uterus with radium. I can well remember how chagrined I felt when a doctor from Cincinnati visiting our meeting most scornfully criticized me for daring to present before this Society any report on the treatment with radium of any form of cancer in the human body. However, some of my very kind friends left very encouraging impressions.

Since Dr. Howard Kelly, of Baltimore, had a large amount of radium at his disposal, he and Dr. Curtis F. Burnam collaborated and obtained some very encouraging results. I mention Howard Kelly and John G. Clark in particular, because I knew that they had devised an operation, and had performed many operations for cancer of the uterus and uterine cervix. In spite of this fact, Dr. John G. Clark had entirely given over the treatment of cancer of the uterine cervix to radium. He told me at one time that the number of cases operable or considered operable was comparatively small; and among those cases, the percentage of cures by operation, while fair, was small indeed.

In other words, at that time we saw a great many patients for whom we could do nothing. I can remember well, before the time of radium and the treatment of cancer of the cervix, all we could do was to scrape out the bleeding tissue, to stop the hemorrhage, and then use a cautery or soldering iron or chloride of zinc applications in an attempt to heal these lesions over and thus try to stop the bleeding and foul discharge. The Percey operation was attempted

about that time. I saw many of the patients who had been treated by this method and they were anything but comfortable. Their sufferings were indescribable.

Those I saw had extensive sloughs and fistulas both into the rectum and into the bladder. I saw many cervix cases operated on by competent surgeons; and about 15 per cent of those who remained well had ureteral and bladder fistulas and many had recto-vaginal fistulas. These patients were subjected to very extensive procedures which brought them almost no relief.

ADVENT OF RADIUM TREATMENT

My father, Dr. Edward J. Ill, who had many years' experience with this sort of treatment for cancer of the uterus, was encouraged and relieved to find a new method of treatment for this miserable condition. Treatment with radium gave patients very little discomfort. They were in practically no danger. The immediate mortality was non-existent. Most of them had two or three years' freedom from discharge, bleeding, and pain; and a certain percentage, even in the inoperable extensive cancer cases, were free from cancer for five years and over. Eighty per cent of cases of cancer of the cervix are histologically radio sensitive. Certainly the treatment of cancer of the uterus has been under rigid scrutiny for the past twenty years, and many patients now are well and free from the disease who would otherwise have succumbed in a miserable way long ago.

The uterus is the most frequent location of cancer in women. Figures differ a great deal by different authorities, but cancer of the uterus comprises approximately 30 per cent of all cancer cases. Since one-third of cancer cases in women are in the uterus, we must be constantly alert, because early recognition of cancer is an absolute necessity if we are going

to improve the results of treatment, whether surgical or by radiation. About ten per cent of the uterine cases are in the corpus, and 20 per cent in the cervix.

CANCER OF THE CERVIX

The frequency of cancer of the cervix is attributed to the fact that there is so much trauma, erosion, scar tissue and infection as a result of childbearing. In other words, there is constant chronic irritation. Chronic endocervicitis is present in nearly all such cases. The frequency of the disease in unmarried women is so strikingly low that there seems to be no question that early treatment of these conditions is most important.

Early cancer lesions of the cervix are rarely recognized because of the lack of symptoms. Usually the cancer lesion is found to be an extensive induration and swelling, a friable ulceration of the cervix, or an extensive papillary or cauliflower outgrowth. This describes the pathology of cervical cancer, and also gives some information as to the prognosis and treatment with radiation.

Extensive induration is apt to produce obstruction in the ureter and rectum.

The association of corpus carcinoma with myoma is still an unsettled question. In fact, I have seen very few cases of carcinoma of the uterus associated with fibroids. It should be remembered that 28 per cent, according to Hoffman, of all women after thirty-five years of age have fibroids. These figures have been collected from autopsy records at Johns Hopkins Hospital and Massachusetts General Hospital, and are very reliable autopsy figures.

I do not mean to say that because a woman has cancer of the cervix or body, there cannot be a fibroid, but it should be borne in mind that every fourth woman over thirty-five years, the time of life when cancer is most frequent, has fibroids.

METASTASES

In my experience distant metastases are unusual. I have carefully followed all my cases of cancer of the uterine cervix,—over 1000,—and I have even gone over the records in the Bureau of Vital Statistics at Trenton and

searched the death certificates very carefully. This search has confirmed the above statement. The uterus is very similar to the rectum in that, while the disease progresses rapidly by direct growth, distant metastases are unusual. For example, I had one patient with cancer of the cervix who had had a resection of the breast for cancer five years before. Both carcinomas were of an entirely different type. The patient is still free from the disease. I have often observed how rarely distant metastases are really found.

The infiltrating form of carcinoma is less apt to result in a favorable outcome with treatment or operation than the papillary and productive outgrowths. The productive growths are most sensitive to radium. I have seen very large cauliflower carcinomas, almost filling the vagina, respond quickly and successfully to radium.

Atrophic, ulcerating, and indurating types are less apt to respond to such treatment. In a paper which I read before the State Society about sixteen years ago, I had already spoken of this observation; and Broder's classification, I have since learned, confirms my clinical observation. Clinical observation, in my opinion, is most important. Very active growths are usually in groups No. 3 and No. 4, and inactive growths or less malignant types are in groups No. 1 and No. 2. The latter are not as susceptible to radiation. It is a striking fact that young women with cervical cancer respond very quickly to treatment with radium; whereas we are all familiar with the fact that other cancers in young women kill very quickly. This is due to the absence of lymphatics in older women, and to the fact that the productive cancer shows a greater differentiation of cell forms than the atrophic type which is a single cell or undifferentiated.

HISTORY OF CERVICAL OPERATIONS

It has been only about seventy years since Sims first suggested curettage with the removal of sloughing masses of cancer from the cervix and cauterization with zinc chloride. About that time Joseph Byrnes, of Brooklyn, suggested and carried out the removal of the cervix with hot electric wire. None of Sims'

patients ever got well, but Byrnes had a number who remained well. It was about 1880 when Leopold first suggested total vaginal extirpation with rather indifferent results. However, total extirpation in cancer of the corpus has proved successful. The operation is done from above, and after the broad ligaments have been ligated down to the vagina so that reinfesting the tissue is not possible, the abdomen is closed; and then the uterus and tubes and ovaries are removed from the vagina. The results have been almost universally satisfactory.

Treatment with radium in this country was first done by Robert Abbey at St. Luke's Hospital in New York approximately thirty years ago. Dr. John G. Clark stressed the fact that very few cases sent in were operable,—and by operable he meant those in which the disease could be entirely eradicated by surgical excision. Any case can be subjected to operation, but it is not operable unless, as I have said, it can be completely removed beyond the cancer. The problem of transplantation is always before us. This accounts for the failures in the operative treatment for cancer of the cervix. Any patient with cancer of the breast can be operated on; but I am very certain that, when they have extension into the axilla, they offer very little chance for permanent cure.

Dr. Clark gives figures to show that 30 per cent of the moderately advanced cases of cancer of the cervix treated with radium remain well for five years and over. Of course different clinics show 30 per cent, 40 per cent and even 50 per cent cures. These are only the very early cases, and the figures are debatable. We must report on all cases treated to arrive at honest figures on how many remain well. Selecting cases and giving glowing figures does not tell the real truth. Cullen's figures show that, of cervical cancer, 50 per cent, and corpus cancer, 16 per cent, were inoperable when first seen. We must consider these figures because they are obtained from the few outstanding surgeons with wide experience and great ability. For example, Cullen reported 16 per cent cures of cervix cancer, and 66 per cent of corpus cancer. I am certain that we all fully realize that corpus cancer in many

cases is a very benign tumor. There are many surgeons among us who are particularly expert; but generally speaking, patients go to men of limited ability and have to be cared for by them. I know of a great many cases of corpus cancer operated on by my father and myself who are still well many years after the excision of the uterus.

I have just as many who have remained well with radium treatment, and the latter did not have the severe operative procedure. I have rarely had a successful five-year cure of cancer of the cervix by operation, and I had occasion to operate on some very early cases. I can, however, remember excising a very early cancer of the cervix with an ordinary cautery, and from my own recent knowledge I know it has not recurred. This operation was performed seventeen years ago. The case was accidentally discovered, and is the exception.

TOTAL EXTIRPATION

There is a principle in the treatment of cancer which cannot be ignored. When cancer is being operated on, the entire mass of cancer must be removed in one piece, and well beyond the growth. If cancerous tissue is cut into or cut across, the case is immediately hopeless. Most of the cases I see show some extension to the broad ligament, or to the vagina. If these patients were operated on, they would enjoy but a very few pleasant months of life.

PLEA FOR RADIUM

My apology for presenting this subject to you is based on the fact that, when we started in 1919 to treat cancer of the uterus with radium, there was very strenuous opposition. Even today operating rooms show a schedule of operative procedure instead of radium treatment. It is interesting to note that even Dr. James Ewing, at one of the annual dinners of the American Society for the Control of Cancer, was asked by my father what he thought of radium treatment for cancer and he said, "I think sometime we shall have to consider radium for the treatment of cancer." You all know how ardent and enthusiastic he is about radium at the present time.

Unfortunately, in spite of the extensive at-

tempt at education and the meritorious work in this line by the American Society for the Control of Cancer, very few early cases come to the notice of physicians. This statement is borne out in the September, 1939, number of *Surgery, Gynecology and Obstetrics*. In 1938 more than 137,000 pamphlets were distributed by this society; 196 lectures were given, eleven radio talks were made, and exhibits were displayed for 572 days. This society has done this sort of work since 1912. I need not inform you that a program for education has been active and constant all this time; but in spite of all these efforts the mortality from cancer is steadily rising. In the state of New Jersey, there is a steady and progressive increase, according to reports by the New Jersey State Department of Health. A report recently edited by Dr. Russell S. Ferguson, Director of the New York State Legislative Cancer Survey Commission, showed cancer mortality rising very markedly in New York State. I have examined all the reports for the last twenty years issued by the Mutual Benefit Life Insurance Company of Newark, and each one definitely states that cancer is increasing. This definite fact is universally supported by Bureaus of Vital Statistics. It can not all be due to the fact that more people live longer and reach the cancer age.

The medical profession has a responsibility. The urban population is 54 per cent of the total for the United States. Certainly the urban population is cancer-conscious. Clinics are established in all hospitals. Cancer has been operated on, treated with caustics, cautery, and radiation. Definite and honest reports of cures are certainly many. Large sums of money have been spent; and yet the cancer mortality is on the increase. A recent report of the survey made by the committee appointed by Governor A. Harry Moore of New Jersey on the statistics of medical care in New Jersey showed that a large number of x-ray machines have been installed and that many operations are performed daily, and still the number of cancer patients is growing larger. The survey states that the total amount of radium owned and used by physicians and hospitals in New

Jersey yearly is 6,304.4 mgs. Over 20,000 radium seeds were purchased and used in 1939.

I may seem to have digressed from my subject, "The Treatment of Cancer of the Uterine Cervix and the Breast with Radium"; yet I have not digressed because I can quote from many papers which show the encouraging results obtained from this treatment of cancer of the cervix. I have seen and treated about 1000 uterine cancer cases since 1919. About 30 per cent of the total lived and were free from the disease for a period of five years or more. Of course many were old people who died from some intercurrent disease. In looking over the death certificates at the Bureau of Vital Statistics in Trenton, I found many patients who had died from pneumonia, arteriosclerosis, and arterio renal disease, as well as other maladies. No mention was made on these certificates of the cancer which these patients previously had. One patient whose case I very carefully followed was a suicide. Because after six years I suspected a recurrence and I advised either examination and perhaps more radiation, she became worried and killed herself. I learned from the death certificate that she had been autopsied by Dr. Martland, of Newark. He made a very careful examination at the autopsy and found no cancer.

I have been much concerned because of the increase in general cancer mortality. I am particularly influenced because nearly all my patients are women; and when you have seen and treated and followed the results of about 1000 cases of cancer of the uterus over a period of twenty years, observations must be of some value.

I am not going to bore you with extensive statistics. A very high percentage of uterine cancer cases are well after treatment with radium. As I have previously stated, we are interested in the general average. It has been very difficult to keep an exact check on my own records, upon which I have based this paper; but it shows very definitely that, when women present themselves because of cancer of the uterine cervix, the disease is already in a far-advanced stage. This is due to faulty education of the public, and incomplete examinations by

physicians. The treatment of cancer of the cervix with radium has been very encouraging.

Since 1925 I have treated nearly all of the very extensive cases with deep voltage x-ray in addition to the radium and I believe this a very valuable adjunct. However, before that time I treated many cases with radium alone and have many cures.

CANCER OF THE BREAST

I also wish to present very briefly for your consideration the subject of cancer of the breast. It is a fact that no one has improved on the results obtained by Dr. Halstead and his most efficient method of operation.

It has been my custom to treat patients with extensive axillary involvement at the time of the operation with a radium pack placed in the axilla.

Five-ten mgs. needles in individual brass capsules separated, in line, covered with non-conducting material, namely gauze, the gauze covered with rubber dam, so as to make removal easy after prescribed number of hours. The pack should be exactly 2 cms. in diameter and tied in place in order to keep the radium in place. The length of the pack should be long enough to cover the axilla.

In January, 1939, I wrote to Dr. J. M. Finney in regard to the treatment of cancer of the breast. He had written a monograph on cancer of the breast in Keene's Surgery, which was edited in 1907. At that time he was an associate of Dr. Halstead in Johns Hopkins Hospital. I inquired of Dr. Finney as to whether he had changed his opinion as expressed in this most complete monograph, and let me quote his reply:

"After thinking over the article, I really don't see anything to change. With regard to the use of x-ray and radium, I must say I have not had any great satisfaction with the use of either of them. I do not use them before operation. I operate as soon as possible after first seeing the patient. As soon as the wound is thoroughly healed, I usually have the breast thoroughly radiated by competent x-ray men. Whether this does any good or not, I don't know; but I feel that in the present state of our knowledge the patient should be given the benefit of the doubt. The x-ray undoubtedly does good in some cases of local recurrence. I am not enthusiastic about it at all."

CANCER OF THE AXILLA

In 1921 my father operated on a patient who had extensive axillary involvement. This was proved by biopsy made by Dr. John W. Gray, of Newark. I am sure you will agree with me that patients with axillary involvement are very doubtful cases for eventual cure. Statistics vary from zero to 20 per cent, as far as the successful treatment of this condition is concerned. In this particular case my father suggested the use of a radium pack in the axilla because he stated at the time of the operation—"These are all bad cases and often have distant metastasis and die." A similar case presented itself the same year, and I have a letter from Dr. Bloodgood, who writes:

(1934)

"This was a colloid carcinoma. I saw the slides and tissue in 1921. This is a remarkable case for an operative treatment in stages, and also x-ray treatment for involved supraclavicular glands."

Both of these patients are still living and free from the disease. I have had similar cases successfully treated by this method.

CASE REPORTS

CASE ONE

In 1935 the late Dr. Whitman Leyenberger asked me to be present at an operation for cancer of the breast. This woman had extensive axillary involvement. At the time of the operation the involvement could not be removed because it was fixed everywhere. I am sure you will agree that this type of patient has no chance for a long life. I implanted a large amount of radium in the patient's axilla. In fact, I placed the radium in needle form as nearly as I could, to cover the entire cancerous mass. A year and a half later she had pain and a fistula in the axilla. X-ray pictures showed sloughing in two ribs. I believed this to be a metastasis in the bone. However, I resected both ribs; and biopsy at St. Michael's Hospital by Dr. John W. Gray showed the rib not to contain cancer. It was radium necrosis. The incision healed kindly, the fistula closed, and my examination on April 25, 1940, showed this patient to be entirely well and free from cancer.

CASE TWO

Another case sent by Dr. Ray T. Munger, of Plainfield, about this time had a similar condition, namely, a very extensive inoperable cancer in the axilla. This patient was also treated with a radium pack. She is now living and free from cancer although she has paralysis in her musculo-spiral nerve from the excessive dose of radium.

I am not going to take your time with a list of these cases which did not have x-ray treatments. "One swallow does not make a summer." However, it is significant to note that a certain number of inoperable and extensive cancer of the breast cases have lived many years, and have not had recurrences after the use of this method of treatment, viz.: combination of resection of the breast, and implantation of a radium pack in the axilla. I do not wish to leave you with the impression that this procedure works in all extensive cases, but I do not know of any other combination of radiation plus operation which has given such satisfactory results in extensive cases.

The Memorial Hospital in New York has not issued any report as to the efficacy of the combination of x-ray and surgery. Dr. W. H. Kraemer of the Jefferson Hospital in Philadelphia, and the Mayos of Rochester report that in their hands, x-ray therapy plus operation has been of no actual benefit. In Surgery, Gynecology and Obstetrics, February, 1935, Dr. Harrington of the Mayo Clinic said:

"The most efficient surgical treatment for cancer of the breast is a thorough, primary amputation."

"The end results on cases in which patients have died showed that the patients who were subjected to surgery alone lived longer than those who were subjected to surgery and Roentgen therapy. In these cases it was shown that Roentgen therapy was not an aid and may in some cases to have been detrimental."

SURVEYING THE RESULTS

After eighteen years of personal experience with x-ray I have arrived at the same conclusion. I was encouraged in the thought of the combination of implantation of radium in the axilla at the time of operation by Dr. Burton J. Lee. At the Memorial Hospital in New York he showed that the breast could be sterilized with deep voltage x-ray; but it was impossible to sterilize the axilla. I know of only

one other man who has reported the method of the combination of operation and radium implantation, and he is Dr. Hugh H. Trout of Jefferson Hospital, Roanoke, Virginia. His report appeared in the A. M. A. Journal in the early part of 1938. This combination of operation and immediate implantation of radium in the axilla has not been given a fair trial by most clinics.

I have neither given you a definite report of the number of cases of each type of cancer; nor have I spoken of various other methods of treatment or the variations of the methods, nor the fact that some cases were treated with x-ray in addition to radium. I have not discussed the number of recurrences or the mortality; but I wish to bring to your attention particularly, if I may, that cancer is definitely becoming much more prevalent,—and this is not due entirely to the fact that people live longer and are therefore more likely to be in the cancer age.

We as doctors are confronted with this problem. We must have a more definite constant *survey of the results of treatment*. An unbiased, disinterested person should satisfactorily gather statistics, corollate them, and report results. They should be at the disposal of a group in our State Society who are particularly interested in cancer, its diagnosis and treatment. We may be subjecting patients to many extensive and tiresome treatments which are not effecting a cure or giving them beneficial results. It is my firm belief that a great deal of the present interest in the treatment of cancer in the human body with radium is because of the very favorable results obtained with the treatment of the uterine cervix with radium. Large doses can be used in the uterus. It is the large dose used in the uterus which makes it possible to obtain cures, along with the fact that cancer of the uterus so infrequently metastasizes to distant parts of the body.

THE SURGICAL ASPECTS OF PERIPHERAL VASCULAR DISEASE *

By HAROLD HANTMAN, M.D., Newark, N. J.

Modern vascular surgery has more to offer than terminal amputation. Indeed, before the doctor attempts surgery on these patients he must be sure that conservative treatment will not suffice; he must be reasonably sure that the surgery proposed will do more good than harm. This he can decide by a painstaking application of the diagnostic steps, by a proper interpretation of these tests, by a clear understanding of the underlying pathologic physiology and by the exercise of good common sense.

Let me outline what the surgeon can accomplish in peripheral vascular disease:

1. Relief of pain.
2. Improvement of circulation.
 - (a) Ligation of femoral vein.
 - (b) Release of vascular spasm by surgical attack on sympathetic system.
3. Amputation.
4. Removal of emboli.
5. Treatment of aneurysms.

RELIEF OF PAIN

The lower extremity is supplied with five sensory nerves. By sectioning or crushing one or a combination of these nerves it is possible to render insensitive any painful area on the toes or foot. The problem is to choose the suitable case; in arteriosclerosis obliterans the extensive involvement of the skin vessels often militates against primary union. Most patients in this group ultimately need amputation anyhow. But in the younger patients suffering from the agonizing pain of thrombo-angiitis obliterans, we have found crushing or sectioning most useful. The abolition of pain facilitates dressings, eliminates the need for narcotics and reduces the urge to smoke. Local circulation may be increased because of the interruption of the sympathetic fibres in the peripheral nerves.

Because the anaesthesia may last from three to six months these patients must be cautioned

and protected against trauma: chemical, thermal, or mechanical.

RELEASE OF SPASM

The place of sympathetic surgery in peripheral vascular disease is not firmly established. Indications are not clear and authorities are still wrestling with the problem of nerve regeneration, the value of pre-ganglionic versus post-ganglionic section, and the inherent sensitivity of capillaries to circulating epinephrin.

Most patients with arteriosclerosis obliterans and moderately advanced thrombo-angiitis obliterans show little evidence of vasospasm and therefore are not suitable for sympathetic surgery. Whatever spasm they may have can be controlled by conservative measures. In certain select cases, however, such as advancing Raynaud's disease and occasionally early Buerger's disease, the vasospastic component may be so prominent as to demand sympathetic surgery before irretrievable damage to tissues has taken place.

Before submitting these patients to sympathetic surgery it is often wise to try a procaine or alcohol block of the ganglia to estimate the probable benefit to be derived from actual surgery.

AMPUTATION

Despite adequate, conscientious medical care, many of these patients develop increasing toxemia and massive gangrene. It requires nice judgment and experience to decide when to stop conservative treatment. It is wrong to temporize too long in a futile effort to avoid amputation. By so doing we prolong the agony and deplete a body ravaged by pain, dehydration, old age, or perhaps diabetes. If two or three weeks of conservative treatment fails, further non-radical therapy will likely be of no avail.

* Read at the Annual Meeting of The Medical Society of New Jersey, May 20, 1941.

Before resorting to amputation we try to restore the fluid and chemical balance of these patients. Then by means of cutaneous temperature readings or histamine flair tests we decide upon the level of amputation. We must be guided by the patient's age, the disease process, the extent of gangrene and infection and the future possibility of weight-bearing on an artificial limb. Rapidly extending infection may demand a prompt "chop amputation" with stump revision later. We try to be as conservative as possible. In the younger age group we try to preserve the knee joint and follow Beverly Chew Smith's technique. In the older age group, however, amputation below the knee is seldom successful because of the extensive involvement of the vascular channels; furthermore these patients seldom adjust themselves to an artificial limb and are in constant threat of involvement of the other limb.

In practice the following procedures are commonly applied:

1. Amputation of toe or through the metatarsals.

2. Beverly Chew Smith amputation.
3. Callandar technique.

HEPARIN

Heparin has ushered in a new era in the field of vascular surgery. This drug is a powerful anti-coagulant derived from animal tissues, especially the lung. Its mode of action is not thoroughly understood, but we do know that with adequate intravenous doses of heparin it is possible to raise and maintain a clotting time at any desired level for any length of time.

In the past, the chief difficulties encountered in arterial suturing were (1) the reactive intimal changes and (2) the secondary thrombosis of the arterial wall at the site of trauma. Even early embolectomy was fraught with danger of secondary thromboses. The immediate use of heparin and its continuation for at least two post-operative weeks, prevents this secondary clotting. Recent literature reveals a growing number of embolectomies with successful restoration of the circulation.

196 Roseville Avenue

CHEWING TOBACCO

Data supporting the concept that chewing tobacco is a factor in the development of cancer of the mouth were recently presented in the J. A. M. A. by H. L. Friedell, M.D., and L. M. Rosenthal, M.D. They report eight cases in which they believe the relationship proved.

The eight patients gave a history of having chewed tobacco for an average of fifty years, with daily retention of the quid for from two to ten hours.

"The first symptom referable to the lesion," the authors say, "was usually soreness, and as the lesion progressed it became more painful. In these cases the point of origin corresponds exactly to the areas in which the quid was held.

"The lesions developed slowly, one patient

having had symptoms for eleven years and two others for more than three years. They were slow to invade the neighboring lymphatics and only one of the eight patients had definite metastasis. * * *

"The lesions responded well to radiation therapy and showed prompt regression. * * *"

Cancer of the mouth develops at the point at which the tobacco quid is held. Further evidence that tobacco chewing is a causative factor of such cancer is had in the literature on betel chewing in the Orient. The betel chew consists of the betel leaf and nut prepared with tobacco and lime. Where the practice is to chew just the betel nut and leaf, cancer of the mouth does not appear to be prevalent.

WORKMEN'S COMPENSATION AND THE GENERAL PRACTITIONER

Compiled by the Advisory Committee on Workmen's Compensation of The Medical Society of New Jersey, 1940-1941, W. K. Harryman, M.D., Chairman

Those of us who see many compensation cases have observed that the average general practitioner has little real concept of many of the salient points in the Workmen's Compensation Laws of our State. This is detrimental to his own interest and to that of his patients. It is also often unfair to the insurance carrier who must have accurate records upon which to base an estimate of proper reserves set up to take care of possible medical expenses. Our Committee, therefore, feels that a perusal of the following will clarify many of the more important points and thereby assist our fellow practitioners.

POINTS TO REMEMBER IN TREATING ALL COMPENSATION CASES

1. You have three parties to consider—your patient, the insurance carrier, and yourself.

2. Treat all compensation cases as thoroughly and as courteously as your private patients. Make each patient feel that you are taking a real and personal interest in him. Unless you first obtain your compensation patient's confidence you will get poor results and possible later criticism. Let an antagonistic patient go to another physician for further treatment rather than try to hold him under these conditions.

3. The carrier pays the bills and represents the employer. He must have prompt and accurate records in order that he may put aside proper reserves. He cannot pay the money to the injured party unless he has the necessary papers and knows the prognosis. Give full details in each report and if complications arise or consultants are needed later, advise the carrier at once. Make fair charges for the services rendered. The carrier expects to pay fair charges, but will contest excessive amounts. If these suggestions are followed, not only will

the carrier have a good picture of the case in his files, but, our experience shows, there will be few arguments over bills. In such disputes the doctor himself is often at fault in that he has not kept the insurance company aware of the unusual or unexpected developments, or he has not fully explained large bills. Do your share—the rest is up to the carrier. You will find him helpful, coöperative and appreciative.

4. Give the best treatment you can and you in turn will benefit by added experience and the satisfaction of aiding in a good recovery. Make friends of your patients and of the carrier. You will find that both will reciprocate and that, as a result, your practice and your income will increase.

EXCERPTS FROM THE LAW

The following excerpts from the Workmen's Compensation Law, State of New Jersey, are the ones most frequently applicable and of most interest to physicians.

The Workmen's Compensation Law comes under the classification of "Remedial Legislation". This means that its provisions are liberally construed. The provisions of the law were created in order that a greater number might obtain the benefits of its protection than was possible before the law was passed.

NEGLIGENCE

34:15-1. *Employees' right to recover for negligent injury*; willful negligence as defense; jury question. When personal injury is caused to an employee by accident arising out of and in the course of his employment, of which the actual or lawfully imputed negligence of the employer is the natural and proximate cause, he shall receive compensation therefor from his employer, provided the employee was himself not willfully negligent at the time of receiving such injury, and the question of whether the employee was willfully negligent shall be one of fact to be submitted to the jury, subject to the usual superintending powers of a court to set aside a verdict rendered contrary to the evidence.

TEMPORARY DISABILITY

34:15-12. *Schedule of payments.* Temporary disability. a. For injury producing temporary disability, sixty-six and two-thirds per cent of the wages received at the time of the injury, subject to a compensation of twenty dollars per week and a minimum of ten dollars per week; if at the time of the injury the employee receives wages of less than ten dollars per week, then he shall receive the full amount of such wages per week. This compensation shall be paid during the period of such disability, not, however, beyond three hundred weeks.

TOTAL PERMANENT DISABILITY

Permanent total disability. b. For disability total in character and permanent in quality, sixty-six and two-thirds per cent of the wages received at the time of injury, subject to a maximum compensation of twenty dollars per week and a minimum of ten dollars per week; if at the time of injury the employee receives wages of less than ten dollars per week then he shall receive the full amount of wages per week. This compensation shall be paid for a period of four hundred weeks at which time compensation payments shall cease unless the employee shall have submitted to such physical or educational rehabilitation as may have been ordered by the rehabilitation commission, and can show that because of such disability it is impossible for him to obtain wages or earnings equal to those earned at the time of the accident, in which case further weekly payments shall be made during the period of such disability, the amount thereof to be the previously weekly compensation payment diminished by that portion thereof that the wage, or earnings, he is then able to earn, bears to the wages received at the time of the accident. In calculating compensation for this extension beyond four hundred weeks the minimum provision of ten dollars shall not apply. This extension of compensation payments beyond four hundred weeks shall be subject to such periodic reconsiderations and extensions as the case may require, and shall apply only to disability total in character and permanent in quality, and shall not apply to any accident occurring prior to July fourth, nineteen hundred and twenty-three.

Total disability is 400 weeks. Where *partial-total disability presents itself*, the quotient used under the law is 500 weeks, so that it is conceivable and possible for a man to be, let us say, 90 per cent partially-totally disabled, which would entitle him to more weeks' compensation than if he were totally disabled. This is readily understood when one knows that there is an agency set up under the workmen's compensation law whereby when a man is totally disabled and he cannot be rehabilitated that he can petition for compensation for life. This would not apply to the man who was partially-totally disabled, which implies that he still had some earning capacity.

PARTIAL PERMANENT DISABILITY

c. For disability partial in character, but permanent in quality, the compensation shall be based upon the extent of such disability. In cases included in the following schedule the compensation shall be that named in the schedule, to wit:

Thumb. d. For the loss of the thumb, sixty-six and two-thirds per cent of daily wages during sixty-five weeks.

First finger. e. For the loss of the first finger, commonly called index finger, sixty-six and two-thirds per cent of daily wages during forty weeks.

Second finger. f. For the loss of a second finger, sixty-six and two-thirds per cent of daily wages during thirty weeks.

Third finger. g. For the loss of a third finger, sixty-six and two-thirds per cent of daily wages during twenty weeks.

Fourth finger. h. For the loss of a fourth finger, commonly called little finger, sixty-six and two-thirds per cent of daily wages during fifteen weeks.

Phalange. i. The loss of the first phalange of the thumb or of any finger shall be considered to be equal to the loss of one-half of such thumb or finger and the compensation shall be for one-half of the periods of time above specified. The loss of any portion of the thumb or any finger between the terminal joint and the end thereof shall be compensated for a like proportion of the period of time prescribed for the loss of the first phalange of such member.

More than one phalange. j. The loss of the first phalange and any portion of the second shall be considered as the loss of the entire finger or thumb, but in no case shall the amount received for more than one finger exceed the amount provided in this schedule for the loss of a hand.

Great toe. k. For the loss of a great toe, sixty-six and two-thirds per cent of daily wages during thirty weeks.

Other toes. l. For the loss of one of the toes other than a great toe, sixty-six and two-thirds per cent of daily wages during ten weeks.

Phalange of toe. m. The loss of the first phalange of any toe shall be considered to be equal to the loss of one-half of such toe, and compensation shall be for one-half of the period of time above specified.

More than one phalange. n. The loss of the first phalange and any portion of the second shall be considered as the loss of the entire toe.

Hand. o. For the loss of a hand, sixty-six and two-thirds per cent of the daily wages during one hundred and seventy-five weeks.

Under the law the hand extends from the elbow down, but does not include the elbow.

If there is an involvement of the elbow or above, then this is regarded as the arm. The loss of an arm entitles the man to 230 weeks.

Arm. p. For the loss of an arm, sixty-six and two-thirds per cent of daily wages during two hundred thirty weeks.

Foot. q. For the loss of a foot, sixty-six and two-thirds per cent of daily wages during one hundred twenty-five weeks.

The foot (from the knee down) entitles the man to 125 weeks. The leg extends from outside the hip joint to the tips of the toes and rates 175 weeks.

Leg. r. For the loss of a leg, sixty-six and two-thirds per cent of daily wages during one hundred and seventy-five weeks.

Eye. s. For the loss of an eye, sixty-six and two-thirds per cent of daily wages during one hundred weeks.

Tooth. t. For the loss of a natural tooth, sixty-six and two-thirds per cent of daily wages for four weeks for each tooth lost.

Hearing. u. For the total loss of hearing in one ear, sixty-six and two-thirds per cent of daily wages during forty weeks. For the total loss of hearing in both ears by one accident, sixty-six and two-thirds per cent of daily wages during one hundred sixty weeks.

Both hands, etc. v. The loss of both hands, or both arms, or both feet, or both legs, or both eyes, or any two thereof as a result of any one accident, shall constitute total and permanent disability to be compensated according to the provisions of paragraph "b".

Amputation. vv. Amputation between the elbow and the wrist shall be considered as the equivalent of the loss of a hand and amputation at the elbow shall be considered as the equivalent to the loss of the arm. Amputation between the knee and ankle shall be considered as the equivalent of the loss of a foot, and amputation at the knee shall be considered equivalent to the loss of the leg.

Injuries to parts of the body such as a kidney, the spine, the skull, the nervous system, etc., are "non-schedule", but are evaluated in terms of total or partial-total disability.

Other cases. w. In all lesser or other cases involving permanent loss, or where the usefulness of a member or any physical function is permanently impaired, the compensation shall be sixty-six and two-thirds per cent of daily wages, and the dura-

tion of compensation shall bear such relation to the specific periods of time stated in the above schedule as the disabilities bear to those produced by the injuries named in the schedule. In cases in which the disability is determined as a percentage of total and permanent disability the duration of the compensation shall be a corresponding portion of five hundred weeks. Should the employer and employee be unable to agree upon the amount of compensation to be paid in cases not covered by the schedule, either party may appeal to the workmen's compensation bureau for a settlement of the controversy.

The difficulty that doctors encounter is not in reference to the clear-cut cases of schedule loss. It is only when function is affected that the matter of individual evaluation comes into play. This phase of the work calls for individual experience, usually based on experience in similar cases. It entails a good bit of thought on the part of the doctor and the aptitude of the doctor in this respect is only as good as the time and effort he is willing to put to the work.

A good rule to apply where one concerns himself with the partial loss of use of a member, or the body as a whole, is to imagine himself surveying the case through a telescope, envisioning the picture as a whole, and then comparing that with what he regards to be the average normal. This is most important because the law does not concern itself with the work that the man might have been performing at the time he was hurt, but rather wishes to think of the person as an average normal unit.

HERNIA

Hernia. x. Inguinal hernia is a disesae which ordinarily develops gradually, being very rarely the result of an accident. Where there is a real traumatic hernia resulting from the application of force directly to the abdominal wall, either puncturing or tearing the wall, compensation will be allowed. All other cases will be considered as either congenital or of slow development and not compensable, being a disease rather than an accidental injury; unless conclusive proof is offered that the hernia was immediately caused by such sudden effort or severe strain that, first, the descent of the hernia immediately followed the case; second, that there was severe pain in the hernial region; third, that there was such prostration that the employee was compelled to cease work immediately; fourth, that the above facts were of such severity that the same was noticed by the claimant and communicated to

the employer within twenty-four hours after the occurrence of the hernia (days when the business is not in operation, such as Sundays, Saturdays or holidays shall be excluded from this twenty-four-hour period); fifth, that there was such physical distress that the attendance of a licensed physician was required within twenty-four hours after the occurrence of the hernia. In the case of hernia as above defined, the provisions of paragraph "a" of this section and sections 34:15-14 and 34:15-15 of this title shall apply, until such time as the employee is able to resume some kind of work with the aid of a truss or other mechanical appliance. If the employee refuses to permit of an operation the employer shall meet the requirements above specified, pay the reasonable costs of the truss or other appliance found necessary, and also pay compensation for twenty weeks, following which the obligation shall cease and terminate, unless death results from the hernia, in which case the provisions of section 34:15-13 of this title shall apply. However, if the employee shall elect to undergo an operation, by a physician selected by the employer, the employer shall meet all the expense incident to such operation and recovery, not in excess of one hundred and fifty dollars, together with compensation as provided in paragraph "a" of this section during the periods of disability prior to and following the operation, subject to the provisions of said section 34:15-14. If the employee refuses the services of the physician selected by the employer, preferring one of his own selection, the employer shall be relieved of obligations concerning medical expense due to the operation and recovery, but shall pay compensation during the prior and resulting periods of disability. If death results from the hernia or operation, the provisions of said section 34:15-13 shall apply.

WAITING PERIOD

34:15-14. No compensation other than medical aid shall accrue and be payable until the employee has been disabled seven days, whether the days of disability immediately follow the accident or whether they be consecutive or not. These days shall be termed the waiting period. The day that the employee is unable to continue at work by reason of his accident, whether it be the day of the accident or later, shall count as one whole day of the waiting period. Should the total period of disability extend beyond seven weeks, additional compensation shall at once become payable covering the above prescribed waiting period.

MEDICAL SERVICE

34:15-15. The employer shall furnish to the injured workman such medical, surgical and other treatment, and hospital service as shall be necessary to cure and relieve the workman of the effects of the injury and to restore the functions of the injured member or organ where such restoration is possible; provided, however, that the employer shall not be liable to furnish or pay for physicians' or surgeons' services in excess of fifty dollars and

in addition to furnish hospital service in excess of fifty dollars, unless the injured workman or the physician who treats him, or any other person on his behalf, shall file a petition with the Workmen's Compensation Bureau stating the need for physicians' or surgeons' services in excess of fifty dollars, as aforesaid, and such hospital service or appliances in excess of fifty dollars, as aforesaid, and the Workmen's Compensation Bureau after investigating the need of the same and giving the employer an opportunity to be heard, shall determine that such physicians' and surgeons' treatment and hospital services are or were necessary, and that the fees for the same are reasonable and shall make an order requiring the employer to pay for or furnish the same.

There is really no longer a \$50.00 limitation to medical care in any case. If a doctor feels that his bill is likely to exceed this amount, it is good practice for him to acquaint the employer or insurance carrier with this fact.

If the employer shall refuse or neglect to comply with the foregoing provisions of this section the employee may secure such treatment and services as may be necessary and as may come within the terms of this section, and the employer shall be liable to pay therefor; provided, however, that the employers shall not be liable for any amount expended by the employee or by any third person on his behalf for any such physicians' treatment and hospital services, unless such employee or any person on his behalf shall have requested the employer to furnish the same and the employer shall have *refused or neglected* so to do, or unless the nature of the injury required such services, and the employer or his superintendent or foreman, having knowledge of such injury shall have neglected to provide the same, or *unless the injury occurred under such conditions* as make impossible the notification of the employer, or unless the circumstances are so peculiar as shall justify, in the opinion of the Workmen's Compensation Bureau, the expenditure assumed by the employee for such physicians' treatment and hospital services, apparatus and appliances.

MEDICAL FEES

All fees and other charges for such physicians' and surgeons' treatment and hospital treatment shall be reasonable and based upon the usual fees and charges which prevail in the same community for similar physicians', surgeons' and hospital services.

PROSTHESIS

When an injured employee may be partially or wholly relieved of the effects of a permanent injury, by use of an artificial limb or other appliance, which phrase shall also include artificial teeth or glass eye, the Workmen's Compensation Bureau,

acting under competent medical advice, is empowered to determine the character and nature of such limb or appliance, and to require the employer or his insurance carrier to furnish the same.

NOTICE TO EMPLOYER

34:15-17. Unless the employer shall have actual knowledge of the occurrence of the injury, or unless the employee, or someone on his behalf, or some of the dependents, or someone on their behalf shall give notice thereof to the employer within fourteen days of the occurrence of the injury, then no compensation shall be due until such notice is given or knowledge obtained. If the notice is given, or the knowledge obtained within thirty days from the occurrence of the injury, no want, failure, or inaccuracy of a notice shall be a bar to obtaining compensation, unless the employer shall show that he was prejudiced by such want, defect or inaccuracy, and then only to the extent of such prejudice. If the notice is given, or the knowledge obtained within ninety days, and if the employee, or other beneficiary, shall show that his failure to give prior notice was due to his mistake, inadvertence, ignorance of fact or law, or inability, or to the fraud, misrepresentation or deceit of another person, or to any other reasonable cause or excuse, then compensation may be allowed, unless, and then to the extent only that the employer shall show that he was prejudiced by failure to receive such notice. Unless knowledge be obtained, or notice given, within ninety days after the occurrence of the injury, no compensation shall be allowed.

EXAMINATIONS

34:15-19. After an injury, the employee, if so requested by his employer, must submit himself for physical examination and x-ray at some reasonable time and place within this State, and as often as may be reasonably requested, to a physician or physicians authorized to practice under the laws of this State. If the employee requests, he shall be entitled to have a physician or physicians of his own selection present to participate in such examination. The refusal of the employee to submit to such examination shall deprive him of the right to compensation during the continuance of such refusal. When a right to compensation is thus suspended no compensation shall be payable in respect of the period of suspension. On request, the Workmen's Compensation Bureau may examine the x-ray for the purpose of determining the amount of disability due, if any.

REFUSAL BY EMPLOYEE

34:15-23. Whenever it shall appear that an employer is being prejudiced by virtue of the refusal of an injured employee to accept proffered medical and surgical treatment deemed necessary by the physician selected by the employer, or his failure or neglect to comply with the instructions of the physician in charge of the case, the employer is hereby authorized to file a petition with the Workmen's Compensation Bureau, which is hereby empowered to order proper medical and surgical treatment at

the expense of the employer. In the event of refusal or neglect by the employee to comply with this order the bureau shall make such modification in the award contained in the schedule as the evidence produced shall justify.

OCCUPATIONAL DISEASES

34:15-31. a. Compensable occupational diseases shall not include any other than those scheduled below and shall include those so scheduled only when the exposure stated in connection therewith has occurred during the employment, and the disability has commenced within five months after the termination of the exposure.

Occupational diseases: (1) Anthrax; (2) lead poisoning; (3) mercury poisoning; (4) arsenic poisoning; (5) phosphorus poisoning; (6) poisoning from benzene and its homologues, and all derivatives thereof; (7) wood alcohol poisoning; (8) chrome poisoning; (9) caisson disease; and (10) mesothorium or radium poisoning.

34:15-33. Unless the employer during the continuance of the employment shall have actual knowledge that the employee has contracted a compensable occupational disease, or unless the employee or someone on his behalf, or some of his dependents, or someone on their behalf, shall give the employer written notice or claim that the employee has contracted one of the compensable occupational diseases which notice to be effective must be given within a period of five months after the date when the employee shall have ceased to be subject to exposure to the occupational disease, no compensation shall be payable on account of the death or disability by occupational disease of the employee.

34:15-31. b. Willful self-exposure to occupational diseases shall include:

1. Failure or omission to observe such rules and regulations as may be promulgated by the Department of Labor and posted in the plant by the employer, tending to the prevention of occupational diseases.

2. Failure or omission to truthfully state to the best of the employee's knowledge, in answer to inquiry made by the employer, the location, duration and nature of previous employment of the employee in which he was exposed to any occupational disease as herein listed.

THIRD PARTY LIABILITY

34:15-40. Where a third person or corporation is liable to the employee or his dependents for an injury or death, the existence of a right of compensation from the employer or insurance carrier under this statute shall not operate as a bar to the action of the employee or his dependents, nor be regarded as establishing a measure of damage therein. In the event that the employee or his dependents shall recover and be paid from the said third person or corporation, any sum in release or in judgment on account of his or its liability to the injured employee, the liability of the employer under this statute thereupon shall be only such as is herein-after in this section provided.

(a) *The obligation of the employer or his insurance carrier* under this statute to make compensation payments shall continue until the payment, if any, by such third person or corporation is made.

(b) If the sum recovered by the employee from the third person or corporation, after the expenses of suit and attorney's fee or either of them, as hereinafter defined, have been deducted therefrom, is equivalent to or greater than the liability of the employer or his insurance carrier under this statute, the employer or his insurance carrier shall be released from such liability and shall be entitled to be reimbursed as hereinafter provided, for the medical expenses incurred and compensation payments theretofore paid to the injured employee or his dependents.

(c) If the sum covered by the employee as aforesaid, after the expenses of suit and attorney's fee, or either of them, as hereinafter defined, have been deducted therefrom, is less than the liability of the employer or his insurance carrier under this statute, the employer or his insurance carrier shall be liable only for the difference and shall be entitled to be reimbursed, as hereinafter provided for so much of the medical expenses incurred and compensation payments theretofore paid to the injured employee or his dependents as exceeds the amount of such difference.

STATUTE OF LIMITATIONS

34:15-41. *Claims barred after two years.* In case of personal injury or death, all claims for compensation on account thereof shall be forever barred unless a petition is filed in duplicate with the Secretary of the Workmen's Compensation Bureau, as prescribed by section 34:15-51 of this title.

LEGAL POWERS

34:15-60. The commissioner, each deputy commissioner and each of the referees shall have the same power as the court of common pleas to issue subpoenas to compel the attendance of witnesses and the production of books and papers. The fees for the attendance of witnesses shall be such as are now provided for the attendance of witnesses in other civil cases, and shall be paid by the party arranging for the attendance of such witnesses. The subpoenas shall be authenticated by the seal of the department, and either party to any such proceeding may, without charge, secure subpoenas from the commissioner, a deputy commissioner or any referee. Misconduct on the part of any person attending a hearing, or the failure of any witness, when duly subpoenaed, to attend or give testimony shall be punishable by the commissioner, each deputy commissioner and each of the referees, in the same manner as such failure is punishable by the Court of Common Pleas in a case therein pending.

34:15-61. The commissioner, each deputy commissioner and each referee shall have power to administer oaths. Any person who, having been sworn as a witness in any such proceeding, shall willfully give false testimony shall be guilty of perjury.

34:15-64. The commissioner and the deputy commissioners may make such rules and regulations for the conduct of the hearing not inconsistent with the provisions of this chapter as may, in his judgment, be necessary. The official conducting any hearing under this chapter may, in his discretion, allow to the party in whose favor judgment is entered, costs of witness fees and a reasonable attorney fee, not exceeding twenty per cent of the judgment; and a reasonable fee not exceeding fifty dollars for any one witness, or one hundred fifty dollars in any one case, for medical witnesses residing in the state, when in his judgment the services of an attorney and medical witnesses were necessary for the proper presentation of the case. When, however, prior to any hearing compensation has been offered or paid, the reasonable allowance for attorney fee shall be based upon only that part of the judgment or award in excess of the amount of compensation theretofore offered or paid. When the amount of the judgment, or when that part of the judgment or award in excess of compensation theretofore offered or paid, is less than two hundred dollars, an attorney fee may be allowed not in excess of fifty dollars.

EXAMINATION OF FEMALES

34:15-68. In all cases where it shall be necessary to make a physical examination of a female employee in an inquiry to award compensation, the examination shall be made by a female physician if the employee so requests.

EMPLOYERS' REPORTS

34:15-96. Every employer carrying insurance as required by article 5 of this chapter shall make report in accordance with the terms of his insurance policy upon the happening of any accident or the occurrence of any compensable occupational disease in his establishment. Such report shall be prepared in triplicate upon a form, designated as "first notice of accident", to be furnished by the insurance carrier. One copy shall be sent to the Department of Labor, one copy to the insurance carrier, and one copy shall be kept on file by the employer. A supplemental report shall be prepared on a form designated as "supplemental report", and sent in like manner, at the expiration of the waiting period prescribed by section 34:15-14 of this title.

34:15-97. *Report by employer not carrying insurance.* An employer not carrying compensation insurance shall make report of any accident or compensable occupational disease causing a disability extending beyond the waiting period or causing any permanent injury. The report shall be prepared and sent immediately upon the employer's having knowledge of the disability or injury named above, and shall be made out in duplicate upon forms to be secured from the Workmen's Compensation Bureau. One copy shall be mailed to the bureau and one copy kept on file by the employer.

34:15-98. *Report by insurance carrier.* Every insurance carrier writing workmen's compensation insurance in this State shall make report of acci-

dent, or compensable occupational disease, as follows: Immediately upon receiving knowledge of an accident to an employee, or the contracting of a compensable occupational disease, causing a disability extending beyond the waiting period or causing any permanent injury, the company insuring the employer of such employee, shall at once make report to the Workmen's Compensation Bureau on a form prescribed by the bureau. Within three weeks after the carrier has learned of the accident or the contraction of such disease, such carrier shall send to the bureau a second report containing a statement of wages and an agreement to care for the case according to the terms of the compensation law. This report shall be signed by the employee as provided thereon and by the employer or insurance carrier. Immediately upon the carrier's learning that the employee has recovered so as to be able to resume work, the carrier shall prepare a final report, and take the steps necessary to have it signed by the employee, as provided thereon. This form shall also be signed by the employer or carrier and sent to the bureau as promptly as possible.

MEDICAL REPORTS

34:15-100. As a part of the necessary medical service required by the compensation law, the employer or insurance carrier shall, when directed so to do, file with the Workmen's Compensation Bureau copies of such medical certificates or reports as it may have on file.

NONCOMPLIANCE

34:15-101. Every employer, insurer or other person failing to comply with the terms of this article shall, for each offense, be liable to a penalty of not less than ten nor more than fifty dollars, the amount thereof to be determined by and paid to the Commissioner of Labor. Upon refusal to pay such fine, the same shall be recovered in an action at law by the Commissioner of Labor in the name of the State of New Jersey.

DISABILITY TABLE

The disability table on the following page is taken from the statute, and the Committee, of course, is not responsible for any inaccuracies in the schedule.

The schedule is used in the following manner: Compute the disability in terms of the percentage of the member involved; then, from the table, calculate the number of weeks, the left-hand column representing your evaluation of the percentage disability, the numeral under the member giving the number of weeks. If the employee earned less than \$10 a week, compute his compensation rate as ten dollars a week; otherwise, compute the rate as two-thirds of his salary, subject to a minimum of ten dollars a week and a maximum of twenty dollars a week.

For example, suppose you conclude that the arm is one-fourth (that is, 25 per cent) permanently disabled. Find 25% in the left-hand column; under "Arm" is the figure, $57\frac{1}{2}$. This means that the employee should received two-thirds of his salary for $57\frac{1}{2}$ weeks. Total permanent disability of the arm (100% of the arm) represents 230 weeks. Similarly, if the compensable hearing loss represents say, one-fifth in one ear, then looking under the column labelled "Hearing: One Ear", the figure opposite 20 per cent (one-fifth) is "8", meaning two-thirds of the salary for eight weeks. If the disability is calculated in terms of the entire body, that is, the entire functioning human unit, use the last column. Thus, if by reason of an accident or occupational disease the employee is permanently functioning at only one-third the normal average physiologic level, his disability is calculated by looking under the last column for the figure opposite thirty-three and one-third per cent, which is found to be 166 and two-thirds weeks; that is, in this case, the employee would be compensated at the rate of two-thirds of his wages for a little over three years.

Special Note: Members who do not preserve copies of the Journal are urged to remove this colored insert from this issue and to file it as a permanent, practical memorandum. It will be found useful whenever you have occasion to examine a patient who has been injured while at work. Special attention is directed to the table on the next page.

SCHEDULE OF DISABILITIES

Per %	Hand 175 Weeks	Arm 230 Weeks	Thumb 65 Weeks	Fingers				Leg 175 Weeks	Foot 125 Weeks	Toes		Eye 100 Weeks	Hearing		Partial Total
				1st 40 Wks.	2nd 30 Wks.	3rd 20 Wks.	4th 15 Wks.			Large 30 Wks.	Others 10 Wks.		1 Ear 40 Wks.	2 Ears 160 Wks.	
1	1 $\frac{3}{4}$	2.3	.65	.4	.3	.2	.15	1 $\frac{3}{4}$	1 $\frac{1}{4}$	.3	.1	1	.4	1.6	5
2 $\frac{1}{2}$	4 $\frac{3}{8}$	5 $\frac{3}{4}$	1 $\frac{5}{8}$	1	$\frac{3}{4}$	$\frac{1}{2}$	$\frac{3}{8}$	4 $\frac{3}{8}$	3 $\frac{1}{8}$	$\frac{3}{4}$	$\frac{1}{4}$	2 $\frac{1}{2}$	1	4	12 $\frac{1}{2}$
5	8 $\frac{3}{4}$	11 $\frac{1}{2}$	3 $\frac{1}{4}$	2	1 $\frac{1}{2}$	1	$\frac{3}{4}$	8 $\frac{3}{4}$	6 $\frac{1}{4}$	1 $\frac{1}{2}$	$\frac{1}{2}$	5	2	8	25
7 $\frac{1}{2}$	13 $\frac{1}{8}$	17 $\frac{1}{4}$	4 $\frac{1}{8}$	3	2 $\frac{1}{4}$	1 $\frac{1}{2}$	1 $\frac{1}{8}$	13 $\frac{1}{8}$	9 $\frac{3}{8}$	2 $\frac{1}{4}$	$\frac{3}{4}$	7 $\frac{1}{2}$	3	12	37 $\frac{1}{2}$
10	17 $\frac{1}{2}$	23	6 $\frac{1}{2}$	4	3	2	1 $\frac{1}{2}$	17 $\frac{1}{2}$	12 $\frac{1}{2}$	3	1	10	4	16	50
12 $\frac{1}{2}$	21 $\frac{1}{8}$	28 $\frac{3}{4}$	8 $\frac{1}{8}$	5	3 $\frac{3}{4}$	2 $\frac{1}{2}$	1 $\frac{7}{8}$	21 $\frac{1}{8}$	15 $\frac{5}{8}$	3 $\frac{3}{4}$	1 $\frac{1}{4}$	12 $\frac{1}{2}$	5	20	62 $\frac{1}{2}$
15	26 $\frac{1}{4}$	34 $\frac{1}{2}$	9 $\frac{3}{4}$	6	4 $\frac{1}{2}$	3	2 $\frac{1}{4}$	26 $\frac{1}{4}$	18 $\frac{3}{4}$	4 $\frac{1}{2}$	1 $\frac{1}{2}$	15	6	24	75
20	35	46	13	8	6	4	3	35	25	6	2	20	8	32	100
25	43 $\frac{3}{4}$	57 $\frac{1}{2}$	16 $\frac{1}{4}$	10	7 $\frac{1}{2}$	5	3 $\frac{3}{4}$	43 $\frac{3}{4}$	31 $\frac{1}{4}$	7 $\frac{1}{2}$	2 $\frac{1}{2}$	25	10	40	125
30	52 $\frac{1}{2}$	69	19 $\frac{1}{2}$	12	9	6	4 $\frac{1}{2}$	52 $\frac{1}{2}$	37 $\frac{1}{2}$	9	3	30	12	48	150
33 $\frac{1}{3}$	58 $\frac{1}{3}$	76 $\frac{2}{3}$	21 $\frac{2}{3}$	13 $\frac{1}{3}$	10	6 $\frac{2}{3}$	5	58 $\frac{1}{3}$	41 $\frac{2}{3}$	10	3 $\frac{1}{3}$	33 $\frac{1}{3}$	13 $\frac{1}{3}$	53 $\frac{1}{3}$	166 $\frac{2}{3}$
35	61 $\frac{1}{4}$	80 $\frac{1}{2}$	22 $\frac{3}{4}$	14	10 $\frac{1}{2}$	7	5 $\frac{1}{4}$	61 $\frac{1}{4}$	43 $\frac{3}{4}$	10 $\frac{1}{2}$	3 $\frac{1}{2}$	35	14	56	175
40	70	92	26	16	12	8	6	70	50	12	4	40	16	64	200
45	78 $\frac{3}{4}$	103 $\frac{1}{2}$	29 $\frac{1}{4}$	18	13 $\frac{1}{2}$	9	6 $\frac{3}{4}$	78 $\frac{3}{4}$	56 $\frac{1}{4}$	13 $\frac{1}{2}$	4 $\frac{1}{2}$	45	18	72	225
50	87 $\frac{1}{2}$	115	32 $\frac{1}{2}$	20	15	10	7 $\frac{1}{2}$	87 $\frac{1}{2}$	62 $\frac{1}{2}$	15	5	50	20	80	250
55	96 $\frac{1}{4}$	126 $\frac{1}{2}$	35 $\frac{3}{4}$	22	16 $\frac{1}{2}$	11	8 $\frac{1}{4}$	96 $\frac{1}{4}$	68 $\frac{3}{4}$	16 $\frac{1}{2}$	5 $\frac{1}{2}$	55	22	88	275
60	105	138	39	24	18	12	9	105	75	18	6	60	24	96	300
65	113 $\frac{3}{4}$	149 $\frac{1}{2}$	42 $\frac{1}{4}$	26	19 $\frac{1}{2}$	13	9 $\frac{3}{4}$	113 $\frac{3}{4}$	81 $\frac{1}{4}$	19 $\frac{1}{2}$	6 $\frac{1}{2}$	65	26	104	325
66 $\frac{2}{3}$	116 $\frac{2}{3}$	153 $\frac{1}{3}$	43 $\frac{1}{3}$	26 $\frac{2}{3}$	20	13 $\frac{1}{3}$	10	116 $\frac{2}{3}$	83 $\frac{1}{3}$	20	6 $\frac{2}{3}$	66 $\frac{2}{3}$	26 $\frac{2}{3}$	106 $\frac{2}{3}$	333 $\frac{1}{3}$
70	122 $\frac{1}{2}$	161	45 $\frac{1}{2}$	28	21	14	10 $\frac{1}{2}$	122 $\frac{1}{2}$	87 $\frac{1}{2}$	21	7	70	28	112	350
75	131 $\frac{1}{4}$	172 $\frac{1}{2}$	48 $\frac{3}{4}$	30	22 $\frac{1}{2}$	15	11 $\frac{1}{4}$	131 $\frac{1}{4}$	93 $\frac{3}{4}$	22 $\frac{1}{2}$	7 $\frac{1}{2}$	75	30	120	375
80	140	184	52	32	24	16	12	140	100	24	8	80	32	128	400
85	148 $\frac{3}{4}$	195 $\frac{1}{2}$	55 $\frac{1}{4}$	34	25 $\frac{1}{2}$	17	12 $\frac{3}{4}$	148 $\frac{3}{4}$	106 $\frac{1}{4}$	25 $\frac{1}{2}$	8 $\frac{1}{2}$	85	34	136	425
90	157 $\frac{1}{2}$	207	58 $\frac{1}{2}$	36	27	18	13 $\frac{1}{2}$	157 $\frac{1}{2}$	112 $\frac{1}{2}$	27	9	90	36	144	450
95	166 $\frac{1}{4}$	218 $\frac{1}{2}$	61 $\frac{3}{4}$	38	28 $\frac{1}{2}$	19	14 $\frac{1}{4}$	166 $\frac{1}{4}$	118 $\frac{3}{4}$	28 $\frac{1}{2}$	9 $\frac{1}{2}$	95	38	152	475
100	175	230	65	40	30	20	15	175	125	30	10	100	40	160	

THE ADVISORY COMMITTEE ON WORKMEN'S COMPENSATION OF THE MEDICAL
SOCIETY OF NEW JERSEY

W. K. Harryman, M.D., Chairman

SIMULTANEOUS IMMUNIZATION WITH A COMBINED DIPHTHERIA-WHOOPING COUGH VACCINE

PRELIMINARY REPORT OF AN EIGHTEEN-MONTH STUDY

By HENRY SIMON, M.D.,

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and

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Mass immunization against diphtheria has been a routine procedure in Newark since 1936. Fluid toxoid, toxin-antitoxin and alum precipitated toxoid have been used. Schick tests on 7,949 children immunized with two doses of fluid toxoid (given at an interval of two weeks) showed 42 per cent positive. A group of 1,800 children immunized with 1 c.c. alum precipitated toxoid followed three weeks later by 1 c.c. of fluid toxoid produced 4 per cent positive Schick tests.¹ Volk and Bunney² have demonstrated satisfactory immunity following two doses of alum precipitated toxoid. We now give 1 c.c. of alum precipitated toxoid at an interval of one month, for two injections.

For the past two years, whooping cough inoculations as a prophylactic measure have been performed in our clinics.

The success of Kendrick and Eldering³ in reducing the incidence of pertussis in Grand Rapids, using a modified Sauer vaccine has stimulated the work in Newark. A carefully controlled study⁴ of secondary familial attack rates using four injections at weekly intervals, showed that 36.4 per hundred exposures were followed by whooping cough in the injected group, compared with 92.0 per hundred exposures in the non-injected control group. Whooping cough in the injected group was less severe than in the non-injected children.

RATIONALE OF COMBINED THERAPY

Ledingham⁵ emphasized that the age at which a pre-school child may be submitted to immunization against diphtheria is also the age at which this same child might very properly be immunized against whooping cough.

It seemed logical therefore that a vaccine

composed of both alum precipitated toxoid and pertussis organisms might protect against both diphtheria and whooping cough.

The opportunity for using such a combined vaccine presented itself in November, 1939, when W. E. Bunney of the Squibb Biological Laboratories suggested that we study a vaccine they had prepared, 1 c.c. of which contained 10 billion killed pertussis organisms and enough alum precipitated diphtheria toxoid so that each cubic centimeter would stimulate the production of at least 1.5 units of antitoxin per c.c. of serum when injected into guinea pigs.

The pertussis vaccine was prepared according to the methods described by Kendrick and Eldering,³ who use an average of six phase 1 cultures, all of which have been freshly isolated from cases of whooping cough within three months.

OTHER COMBINED VACCINES

Maclean and Holt⁶ have shown that the amount of tetanus antitoxin in the serum of the immunized man was over five times as great, if he were injected with a combined tetanus toxoid, typhoid paratyphoid vaccine, than if the tetanus toxoid was used alone. Reaction to the combined antigen was no greater than to the typhoid, paratyphoid vaccine alone.

1. Craster, C. V.: "The Mass Immunization of Pre-School Children." *J. Med. S. N. J.*, 38:39, Jan., 1941.

2. Volk, V. K., and Bunney, W. E.: "Immunization with Fluid Toxoid and Alum Precipitated Toxoid: preliminary report." *Am. J. Pub. Health*, 29:197, March, 1939.

3. Kendrick, P., and Eldering, G.: "A Study in Active Immunization Against Pertussis." *Am. Journ. Hygiene*, Sec. B., 29:133, May, 1939.

4. Kendrick, P.: "Secondary Familial Attack Rates from Pertussis in Vaccinated and Unvaccinated Children." *Am. Journ. Hygiene*, Sec. A, 32:89, Nov., 1940.

5. Ledingham, J. C. G.: "Prophylactic Immunization Against Measles, Scarlet Fever, Diphtheria, Whooping Cough and Influenza." *Brit. Med. Jour.*, 2:841, Oct., 1939.

6. Maclean, I. H., and Holt, L. B.: "Combined Immunization with Tetanus Toxoid and T.A.B." *Lancet*, 2:581, Nov. 9, 1940.

Jones and Moss⁷ state that when diphtheria and tetanus toxoids are combined, there is no interference with specific immologic responses.

EXPERIMENTS IN GUINEA PIGS

Schütze⁸ studied the protection conferred on guinea pigs by the injection of combined vaccine. He used a subcutaneous injection of a 1½ c.c. pertussis suspension containing 0.1 c.c. of alum precipitated diphtheria toxoid. Two injections were given at an interval of four weeks. An equal number of guinea pigs were inoculated with straight alum precipitated diphtheria toxoid. A Schick test was performed three weeks later. When the above mixture was further diluted 1 to 4, the toxoid alone protected only 2 out of 12 guinea pigs, while the toxoid plus vaccine protected all 11 animals inoculated.

DOSAGE

Children were injected with 1 c.c. subcutaneously for two doses in the upper arm, at either one or two-month intervals.

REACTIONS TO COMBINED VACCINE

The reactions were entirely satisfactory. Care was taken to shake the vaccine thoroughly before use. Children who gave a history of allergy were not injected. The local reactions consisted of slight or moderate erythema varying in size from a five to a ten-cent piece or slightly larger. This erythema was transient, disappearing in three to four days. In many cases a pea-sized nodule was felt under the skin for several weeks. Two per cent of the children had a slight fever for a day or two. There were no abscesses or alarming systemic reactions.

TABLE 1

RESULTS OF SCHUTZE'S GUINEA PIG EXPERIMENTS⁸

Dose of A.P.T.	(A) Without Pertussis Vaccine		(B) With Pertussis Vaccine	
	No. Guinea Pigs	Protected	No. Guinea Pigs	Protected
1/10th c.c. of A.P.T. in 1½ c.c. mixture of 15 billion Pertussis organisms	12	10 87%	12	12 100%
Diluted 1 to 4	12	2 16%	11	11 100%

Schütze concludes that when alum precipitated diphtheria toxoid is combined with pertussis vaccine, the antigenic effect of the toxoid is increased. He does not believe that the immunizing power of the pertussis vaccine is impaired by the presence of the alum precipitated toxoid. Maclean⁹ found that the combination of pertussis vaccine and alum precipitated diphtheria toxoid contained good antigen and stimulated the production of both agglutinins and protective substances in mice.

In order to avoid reactions, it is advised that the strength of the alum precipitated toxoid in the vaccine be not increased.

CRITERIA FOR SELECTION

The same criteria were used in the selection of controlled and immunized children. These children ranged in age from six months to the sixth birthday. There was no previous history of whooping cough and no exposure within 30 days of appearance at the clinic. A total of 840 children received two doses of the vaccine.

FAMILIAL CONTROLS

One problem in any study to evaluate the proportion of exposed subjects who develop whooping cough is the difficulty of being cer-

7. Jones, F. G., and Moss, J. M.: "Combined Diphtheria Toxoid and Tetanus Toxoid. Alum Precipitated. Prolongation of Accelerated Immunity Following Stimulating Dose of Antigen." *J. Lab. & Clin. Med.*, 24:512, Feb., 1939.

8. Schütze, H.: "Simultaneous Immunization Against Whooping Cough and Diphtheria." *Lancet*, 2:192, Aug. 17, 1940.

9. Maclean, I. H.: "Prophylactic Inoculation Against Whooping Cough." *Proceedings of the Royal Society of Medicine*, 32:425, May, 1940.

tain that there is an actual transference of infectious material from the patient with whooping cough to the exposed child. There must be evidence that there was an actual case of whooping cough, and that this patient coughed sufficiently to transfer the pertussis organisms to the exposed child. It is obvious that even if two children play together no true exposure may occur.

If a patient with whooping cough and the exposed child actually live together, in most cases, there can be no question of the exposure; therefore, familial controls were used. When one child in a family was selected as a control, the other children who fulfilled the same criteria automatically became controls at the same time.

FOLLOW-UP ROUTINE

All reported cases of whooping cough and children who had cough plates were checked against our catalogue files to see if they were controls or immunized cases. The first follow-up report was made when the child returned for a Schick test.

We endeavored, when possible, within the limitations of the study, to make follow-up home visits to pick up unreported cases and exposures.

COUGH PLATES

All suspicious coughs, whenever possible, had a cough plate taken. A case of whooping cough was accepted as authentic if there was a history of whooping. If the child was simply coughing and never whooped, it was not accepted unless there was a family exposure or unless a positive cough plate had been obtained.

SEVERITY RATING OF PERTUSSIS

To gage the severity of the pertussis, we used the scale proposed by Kendrick and Eldering.³ This follows:

1. *Very light attack*: Diagnosis depends upon a positive cough plate. Any cough of more than one week's duration and less than four weeks' duration not accompanied by whooping or vomiting is classified as very light.

2. *Light attack*: When the cough does not last more than four weeks and is of a light

nature, accompanied by occasional whooping or vomiting, it is a light attack.

3. *Moderate attack*: The ordinary whooping cough that lasts four to six weeks with characteristic whooping and vomiting with no complications is a moderate attack.

4. *Severe attack*: This is characterized by very severe whooping, vomiting, paroxysms and by loss of weight; and by complications such as broncho-pneumonia and prolonged bronchitis.

SCHICK TEST RESULTS

Schick tests were performed upon 527 children, and 520 or 98.7 per cent negative Schick results were obtained. An interval of at least four months was permitted to elapse after the second injection before a Schick test was performed. The Schick test was read five to seven days after it was made. Five of the seven positive Schick tests occurred in children who had received 1 c.c. of the combined vaccine one month apart.

It was also noted that all of these seven children had not reached their ninth month when they received their second dose of combined vaccine. In other words, no child nine months or over, at the time of the first injection, had a positive Schick test. No positive Schick tests were obtained among the 169 children between nine and twelve months of age. This may prove to be a reason for beginning diphtheria immunization at the age of nine months.

TABLE 2

	Familial Exposures	No. of Cases of Pertussis	Secondary Familial Attack Rate
Controls	29	26	90%
Immunized	11	4	36%

TABLE 3

SEVERITY RATE

	Light	Moderate	Severe
Controls	1	21	4
Immunized	1	3	0

COMMENT

Twenty-nine control children had one or more brothers and sisters who first developed whooping cough in the family.

There were eleven different families, each family containing one child immunized with the combined vaccine, whereas the other members were not injected against whooping cough. A non-immunized child first contracted the whooping cough and introduced it into the family.

The secondary familial attack rate, as defined by Kendrick,⁴ was used in our statistics.

One immunized child coughed lightly for six weeks, with no whooping or vomiting, and if there had been no whooping cough in the family, the diagnosis of pertussis would have been difficult to make, as this occurred in the winter, during an influenza epidemic.

Another immunized child coughed and whooped lightly for three weeks after being exposed to a brother and sister, both having severe three-month cases of pertussis.

In eight of the eleven families, the parents were impressed with the protection given their immunized child as contrasted to their non-immunized children.

SUMMARY

A combined diphtheria-whooping cough vaccine was used on 840 children. The dose was 1 c.c. once a month or once in two months for two injections, subcutaneously unto the upper arm.

There were 98.7 per cent negative Schick tests in 527 children tested. This is a highly satisfactory immunity to diphtheria.

Within the limitations of this eighteen-month study, our statistics indicate that even though we merely used two injections, totaling in all, only 20 billion organisms, some protection against whooping cough was conferred.

We are continuing our study of the combined vaccine by using four injections at monthly intervals.

ACKNOWLEDGEMENTS

The authors wish to express their appreciation to the Squibb Biological Laboratories, New Brunswick, N. J., for furnishing us with the combined vaccine; to Mr. Robert Morgan Second Assistant Health Officer, Newark City Health Department, for invaluable assistance in formulating the study; to Francis Edel, Ph.D., for bacteriologic assistance in making media and interpreting cough plates.

94 William Street

VITALLIUM TO REPAIR SKULL DEFECTS

The patient can be back at work three weeks after the trephine, if vitallium is used to repair the skull defect. So writes Dr. F. W. Geib in a recent issue of the Journal of the American Medical Association. Vitallium is an alloy of cobalt, nickel and chromium. Dr. Geib reports three cases in which vitallium was used to repair cranial defects and says that at the end of eleven, twelve and six months, respectively, x-rays showed no increase in the size of the bony defect nor any shrinkage of the skull away from the vitallium plate. In his conclusions Dr. Geib writes: "Autogenic bone grafts have given the best results up to the present time, although they require secondary incision and complicated operative procedures and may be absorbed.

"Vitallium is neutral in vivo. It is rigid, stronger than bone, noncorrosive and inexpen-

sive and requires a much less complicated cranioplastic operation than any in use at the present time. The patient can be back at work on heavy duty within three weeks after operation.

"A vitallium plate makes the strongest and least complicated plastic repair of the skull known."

The author explains that the third patient reported by him died from other causes eight months after the plate had been inserted and that postmortem examination showed that the vitallium plate was the same as when it was inserted, its high luster was unchanged, the screws firmly embedded in the bone, the soft tissue had grown about the plate up through the slots and small openings and had completely incorporated the plate in a soft fibrous covering. There was absolutely no reaction.

NEUROGENIC FACTORS IN PERIPHERAL VASCULAR DISEASES *

By J. F. PESSER, M.D., Trenton, N. J.

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As all peripheral vascular diseases are tremendously influenced by the sympathetic and parasympathetic nervous system, whose centers are in the mid-brain, it is fitting that a gastro-enterologic internist has been asked to discuss the neurogenic factors of peripheral vascular disease. A more important reason for associating the Vice-Chairman of the State Committee on Mental Hygiene with this symposium was to bring before this group the increasing need of constant recognition of nervous and mental states and diseases, that they may be diagnosed promptly and properly, and then, if need be, sent to the clinic or adequately equipped hospital for treatment and cure.

PHYSIOLOGIC BASIS

Normally the outflowing sympathetic influences distributed to the blood vessels of the body maintain an even arterial tone.¹ The nerves controlling the muscular arteries are distributed from the spinal cord through preganglionic fibers to the sympathetic gangliated chain. Postganglionic neurons pass out with the great nerves of the limbs to ramify over the larger arteries, and finally, just as sensory nerves are distributed to the skin, the vasomotor fibers are assigned to the fine arteries and arterioles of corresponding peripheral fields. Thus a general stimulation of the sympathetic system causes vasoconstriction over the entire body; a stimulus touching only the sympathetic supply to an arm excites vasospasm in that arm. This disorder may even be so local as to effect the vasomotor fibers distributed through a single nerve. Sudomotor and pilomotor excitement is associated with vasomotor constriction.

A feature of the sympathetic system in the hands and feet is the very rich supply of fine arterio-venous connections capable of being closed or widely opened accordingly as the sympathetic fibers contract or relax their walls.

Through these connections, the surface of those terminal parts conserves heat or gives it out. Hence arterial spasm shows itself more plainly in the hands and feet than elsewhere; this is especially true in the fingers and toes. The cold and pallor this occasions are almost necessarily associated with sweating. It is also true that the arterial dilation of sympathetic paralysis leaves the skin of the extremities hot, pink and dry. The variations of these reactions are brought into account in the various vasospastic states.

Best and Taylor² give credit to Karpus and Kreidl as the first to furnish evidence of a sympathetic center in the hypothalamus. Upon electrical stimulation of this region they obtained pupillary dilatation, sweating, and a rise in blood pressure, as well as inhibition of intestinal movements. Liberation of adrenalin has also been reported as result of stimulation of the hypothalamus.

Alpers³ states that the hypothalamus appears to be immediately concerned in the various emotional, intellectual, and personality disorders. The evidence in favor of hypothalamic participation in emotional mechanisms is better than that found in other disorders. "It seems safe to say," writes Alpers, "when the hypothalamus is released from cortical control, or from conscious or subconscious inhibitions, it is capable of giving rise to primitive emotional reactions in animals and to similar reactions in man, as well as to coarseness and a lack of appreciation of social niceties. One might drift into the fancy of asserting that rage, temper, and coarseness of behaviour are hypothalamic in origin."

To use the thought of Ochsner and De Bakey,⁴ I quote, "In the final analysis, periph-

* Read at the Annual Meeting of The Medical Society of New Jersey, May 20, 1941.

1. Homans, J.: *Circulatory Diseases of the Extremities*. Macmillan, 1939.

2. Best, C. H., and Taylor, N. B.: *Physiological Basis of Medical Practice*. Williams and Wilkins, 1939.

3. Alpers, Bernard J.: *Personality and Emotional Disorders Associated with Hypothalamic Lesions*. The Hypothalamus, Williams and Wilkins, 725, 1940.

4. Ochsner, A., and De Bakey, M.: *The New International Clinics*, 3:1 (Sept.) 1939.

eral vascular disease signifies simply a disturbance or actual diminution in the normal amount of circulating blood to a part. This is usually due to varying diminution in the caliber of these vessels. This decrease in intraluminary volume may be caused by obliterative structural change, by abnormal spasticity, or by both, depending on the type and stage of the disease."

Therapy to be effective must aim at improvement in circulation. Obviously this can not be accomplished successfully by an attack upon vessels which have already undergone structural change. However, vasospasm is not an unalterable pathologic lesion, but a physiologic or functional derangement which can be satisfactorily influenced by appropriate therapy. A rational consideration of peripheral vascular disease is possible only from a pathologicophysiology standpoint. Such a concept permits differentiation upon which accurate prognosis and adequate therapeutics are based.

CLASSIFICATION

The following classification is based upon this more rational concept of anatomic and functional disturbances in vessels:

I—Vasospastic functional disease.

II—Vasospastic organic disease.

III—Organic degenerative disease.

The basis of this classification is the presence or absence of vessel spasticity. This is the one controllable factor and therefore of prognostic and therapeutic significance. Vasospasm exists not only in vessels which have undergone structural change, but consistently involves collateral vessels as well. This is classically exemplified by those cases in which symptoms accompanying sudden vascular occlusion can be prevented or alleviated by removing the vasospastic influence.

ETIOLOGIC FACTORS

Hyperidrosis, or excessive sweating, is characteristically associated with vasospastic dis-

eases and is an indication of hypertonus of the sympathetic nervous system.⁵ It is usually a manifestation of vasospastic functional disease but is rarely observed with degenerative organic conditions. The most influential factors in vasospastic conditions are emotional excitement, exposure to cold, and tobacco. In some instances the latter is evidence of further nervous instability. While emotional disturbances are particularly likely to aggravate and even precipitate vasospasm in vasospastic functional disease, they are relatively insignificant in patients with organic lesions. Similarly, exposure to cold is a considerably more important precipitating factor in vasospastic functional conditions, although all peripheral vascular diseases are aggravated by decreases in temperature.

Tobacco smoking⁶ produces definite deleterious effects on the vascular system. It produces marked vasoconstriction of the peripheral vessels in normal persons⁷ as well as in patients with peripheral vascular disturbances. While it is especially harmful in patients with vasospastic functional and vasospastic organic lesions, it probably is deleterious to patients with degenerative organic disease by affecting the collateral vessels.

In the treatment of these conditions, every attempt should be made to avoid emotional excitement such as anxiety, fear, and anger. Stimuli, like cold and emotional excitement, produce vascular spasm by reflex excitation of vasoconstrictor impulses to blood vessels and by reflexly increasing the secretion of epinephrine. Surgical procedures attempt to diminish the neurogenic activity.

Characteristically, the symptoms in the young female with vasospastic functional disease are frequently precipitated by emotional upsets, whereas in the individual with degenerative organic disease, symptoms are little affected by such emotional disturbances. In the patients with vasospastic functional disease we have frequently observed the triphasic color changes initiated merely by presenting the patient to a group of students. Between these extremes, vasospastic functional disease and degenerative organic disease, emotions play a definite rôle

5. Adson, Alfred W.: Physiological Effects Produced by Ablation of the Autonomic Central Influence: Various Forms of Sympathectomy in the Treatment of Diseases. *Surgery* 1:425 (March) 1937.

6. Parwinski, J.: Ueber den Einfluss unmaessigen Rauchens (des Nikotin) auf die gefaesse und das Herz, *Ztschr. f. klin. Med.* 80:284, 1914.

7. Wright, I. S., and Moffat, Dean: The Effects of Tobacco on the Peripheral Vascular System. *J. A. M. A.*, 103:318 (Aug. 4) 1934.

in the development of symptoms in the vasospastic organic lesions.

CLINICAL OBSERVATIONS

Everything else being equal, the younger the individual with peripheral vascular disease the greater is the likelihood of vasospasm playing a prominent rôle.⁸ In persons under thirty, the lesion is usually of the vasospastic functional variety in contrast to the individual over fifty, in whom a vascular disease is almost invariably of the degenerative type. Between these poles lie cases in which there is both an organic occlusion and an associated vasospastic factor. The most typical examples of these groups are the Raynaud's phenomenon in the first, arteriosclerosis with or without diabetes in the second, and thrombo-angiitis obliterans in the third.

Vasospastic lesions are more common in the female than in the male.

The color changes in peripheral vascular disease may indicate the presence or absence of vasospasm. In the degenerative organic disease the conspicuous pallor of the skin changes little or none in different positions. On the other hand, in patients with vasospastic organic disease, there usually occur characteristic postural changes in skin color. As originally described by Buerger,⁹ the skin of the extremity presents a prominent pallor in the elevated position and a violaceous discoloration in the dependent position. In vasospastic functional disease, however, typical triphasic color changes are likely to occur independent of position. These changes are often precipitated by emotions or exposure to cold. The triphasic colors observed in vasospastic conditions are blanching, which at times may simulate a cadaveric whiteness, a

mottled cyanosis, and a reactive hyperemia resulting in marked redness.

Cold and emotional excitement produce vascular spasm by reflex excitation of vasoconstrictor impulses to blood vessels, and by reflexly increasing the secretion of epinephrine. Thus the mechanism of peripheral vasoconstriction under such circumstances may be humeral as well as neurogenic. Surgical procedures represent an attempt to diminish neurogenic activity.

MANAGEMENT

It is within the premise of the internist and psychiatrist to help control the emotional factors which in many instances represents the trigger setting loose the reflex excitations.

In an emotional individual, this task is not easy. General practitioners and internists frequently need to "team up" with the psychiatrist in an attempt to overcome and control these emotional outbursts. It is also the emotionally unstable who are likely to over-indulge in cigarettes. Many of you have patients in whom excessive cigarette smoking is a sign of emotional instability. This too, aggravates the peripheral vascular disease, either directly in the diseased vessels or by influencing the collateral circulation.

In the conservative treatment of this condition, either before surgery or after all surgical and mechanical measures have been exhausted, psychotherapy is an important adjunct in the treatment of all forms of peripheral vascular disease.

8. Ochsner, A., and De Bakey, M.: The Rational Consideration of Peripheral Vascular Disease. *J. A. M. A.*, 112:230 (Jan. 21) 1939.

9. Buerger, L.: *Circulatory Disturbances of the Extremities*. Philadelphia, W. B. Saunders Co., 1924.

CANCER OF THE RECTUM

By HENRY W. CAVE, M.D., New York City

Attending Surgeon, Roosevelt Hospital

Read before the Section on Surgery of the Annual Meeting of The Medical Society of New Jersey
June 5, 1941.

The relatively inaccessible location of carcinoma involving the rectum, from the point of bodily consciousness, explains why these growths may attain considerable size before giving objective symptoms. This is particularly true of the ampulla, where the dimensions of the rectum are at their greatest.

Few individuals are endowed with intestinal habits of such complete regularity that an occasional attack of constipation or diarrhoea would bring real alarm.

The physician is rarely approached for advice only because the patient is conscious of a subtle change in the regularity or character of the evacuations, or a sense of their incompleteness; or simply a vague consciousness of his rectum. He awaits unfortunately the later warning of rectal bleeding before seeking reassurance that he is only suffering from hemorrhoids.

Abdominal discomfort of "gas" is often an early complaint and may be referred to any point along the entire course of the large bowel. The only early symptom may be right upper quadrant pain, simulating that of gall-bladder disease.

The rectal bleeding may come as an early symptom, or the disease may be relatively advanced before it occurs. Certainly it is the most consistent feature in the histories of operated patients, and is usually the factor that induces attendance for an examination. The blood is bright red, and noticed usually on the stool or drips free in the basin. In the later stages of fungating growths this bleeding may be copious.

There continue to be cases who have undergone hemorrhoidectomy as a preliminary treatment, and these should serve as object lessons for routine sigmoidoscopy.

Alternating attacks of constipation and diarrhoea is truly an obstructive phenomenon; and as such should distinctly be interpreted as a later phase of the disease. A point in the life

of the individual where the rectum can be truly said to have undergone a transition from an organ of conscious disability.

To cure more patients is competently to diagnose the disease earlier in its course. The insignificance of the symptoms before bleeding occurs pleads for astuteness on the part of the diagnostician; plus the ability skillfully to employ a sigmoidoscope as a part of routine physical examination.

DIAGNOSIS

Any adult with a vague lower abdominal complaint should be afforded the benefit of a proctoscopic and sigmoidoscopic check-up.

Ninety per cent of all carcinoma of the rectum can be felt by the examining finger. We have found that the squatting posture and with the patient straining would reveal growths that otherwise could not be felt. Upon insertion of the proctoscope, we believe that tissue should be removed for microscopic study. There are proctologists who maintain that this is an unwarranted procedure and advise against it, believing that it may loosen cancer cells which will spread to neighboring lymph nodes. We would be unwilling to submit any patient to a removal of their rectum without positive microscopic findings. It is well to emphasize here the importance of several biopsies, particularly if the first or second pieces taken prove negative for malignancy.

Spot films taken of the rectal pouch and recto-sigmoid frequently are of tremendous value; but a negative x-ray taken does not exclude the presence of a small malignant tumor in this segment of the bowel. At times an air injection will show a defect which otherwise could not be seen.

We have recently operated upon a man with a definite carcinoma of the rectum ten centimeters from the anal opening, in which the barium enema and postevacuation, air injection were reported negative; and yet the base of

this rounded ulcerating carcinoma measured four centimeters in diameter.

DIFFERENTIAL DIAGNOSIS

The most important lesions to differentiate from cancer are adenomata. They occur single, but are prone to be multiple, and have a tendency to undergo malignant degeneration.

This feature makes it most important to obtain three or four biopsies from different areas of any suspected growth; as it is not uncommon to have one area reveal benign tissue while another proves malignant.

A negative report on biopsy should be followed by the further precaution of searching higher with the sigmoidoscope, to eliminate the possibility of additional adenomas.

Amebic infestation of the large bowel may result in the development of an inflammatory lesion in the rectum, which will bleed and simulate clinically an identical picture to that of carcinoma. The gross appearance can be even more misleading; and in one instance we resorted to tissue biopsy on three separate occasion before obtaining a "warm stage" smear from the growth, which revealed amoebae.

Hemorrhoids very frequently confuse the picture as they not uncommonly exist entirely independent of a malignancy; and it is deplorable that such a high percentage of patients suffering from carcinoma of the rectum should first have a hemorrhoidectomy performed for the bleeding, before the true nature of the disease is discovered.

Other conditions to be differentiated are:

1. Diverticulitis—less common in the rectum than in the sigmoid, and therefore less confusing.
2. Lympho-pathia venereum.
3. Ulcerative colitis.
4. Tuberculous colitis.

PATHOLOGY

The pathology of rectal malignancy is not complicated. The commonest type of rectal cancer is a hard, nodular tumor, projecting into the lumen, which, if undisturbed, will completely encircle the rectum. It is usually ulcerated, and the surrounding intact mucosa is moderately inflamed and is oedematous.

A second type is characterized by predominance of fibrous elements over the epithelial make-up, resulting in a small contracted cancerous growth of the scirrhus type; these are rare in the rectum.

A third group is comprised of a bulky growth containing mucinous material, both within the cells and outside in the stroma. These are known as the *colloid* cancers of the rectum.

The fourth type is the papillary growth, the main projection being toward the lumen. It slowly invades the outer coats and metastases are long delayed. In this group, there are seldom deep ulcers or crater formations.

The importance of the spread of cancer cells cannot be overemphasized. This feature is the determining factor of radical removal. Miles¹ has given us an exhaustive study of the lymphatics and vessels through which extension may take place.

Metastases to internal organs are much more numerous than node metastases, but this rests on the fact that their presence is determined in advanced cases, and usually at autopsy. The liver is involved in approximately 40 per cent of the cases, as determined by different authors.

On examination of the bowel, with careful study of the perirectal fat for blood vessel invasion, Brown and Shields-Warren² found the reason for this discrepancy in the numerous examples of vascular invasion by tumor. These were found in all cases except one (69 out of 70) of the cases with metastases in the organs. It therefore seems that careful search of the specimen for invasion of blood vessels is of greater prognostic import in cancer of the rectum than the search and determination of metastases in regional nodes. The absence of vessel invasion is a very favorable finding, if careful search has been made.

OPERABILITY

Operability varies considerably with the individual surgeon. It ranges anywhere from 25

1. Miles: Cancer of the Rectum, 1926; Lettsomian Lectures, Feb. and March, 1923, published by Harrison and Sons, 1926.

2. Brown and Shields-Warren: S. G. & O., 66:611, March, 1938.

per cent to 76 per cent. Rankin has in the past few years attained an exceedingly high rate of operability of 75 per cent. Others who are doing institutional work, particularly where a majority of the patients are in the old age, generally debilitated group, the operability naturally would be lower. It might be said in fairness that, as an operator's ability advances in some measure, so does the rate of operability increase. In one hundred cases reported by Morton³ operability was 34 per cent.

It might be generally stated that any lesion that is movable should be resected unless it is obviously too great a risk to the patient. Needless to say for a patient with a palpable liver, marked cacexia and debility, the term *palliative* should be applied. If there is extensive local invasion, bladder perforation, or any deep fixation of the growth, particularly in people of age seventy or above, in our opinion it is hazardous and meddlesome to subject such a patient to surgery. At the time of exploration, if there are one or two metastatic areas in the liver and the growth is free and easily removable, a difficult problem in judgement presents itself, as to whether to resect this tumor or not. In three such individuals whom we have operated upon with two or three small nodules in the liver, two of these lived for two years with comfort; one lived fourteen months getting some enjoyment out of life.

Frequently, extensive lymphatic involvement in the areas adjacent to the growth does not in itself exclude removal; for this glandular involvement is often inflammatory rather than metastatic. Many of these growths, particularly in the rectosigmoid, are fixed to the surrounding structures; and it is in this group of cases, particularly if the growth is of any size, that operability is increased at less risk by using the Lahey procedure. There are times when by diverting the fecal stream through a colostomy the growth which had at operation been apparently inoperable, may become operable in six to eight weeks.

To elevate the percentage of operability, it is essential that the lesion be diagnosed early, that the surgeon has had wide experience with

rectal growths, that his assistants and nurses have developed smooth and rapid functioning team work; that the tumor has not become too extensive, and that the patient properly prepared can tolerate a formidable surgical manoeuvre.

The successful outcome of any operation on a rectal growth, whether obstructed or non-obstructed, depends in great measure upon a meticulous prolonged pre-operative preparation.

PROCEDURE

In the obstructed group, caecostomy or transverse colostomy is indicated. The operation of dysfunctioning the left colon and rectum of Devine's merits attention. His and others' statistical data have proved that this form of decompression is a life-saving measure, and has diminished unquestionably the operative mortality particularly in the elderly group, and has in the lower sigmoid tumors made it possible to preserve the sphincter. Every patient with a rectal growth should be hospitalized for at least one week pre-operatively. Upon admission to the hospital, if the patient is not obstructed, a dose of castor oil is administered for the purpose of thoroughly and completely cleansing the large bowel. Epsom salts—one-quarter ounce—is given daily up until forty-eight hours prior to operation.

These patients are allowed up two hours in the morning, and two hours in the afternoon to maintain a proper circulatory balance. A high caloric, low residue diet, with 1,000 c.c. of intravenous five per cent glucose twice daily is given. The lower rectal pouch is irrigated once daily with warm saline solution. If the hemoglobin and red blood counts are diminished, one or two moderate size direct transfusions are administered, pre-operatively. Within forty-eight hours before operation lead and opium pills grains one, and paregoric drams one, three times a day are administered in order to contract the lower sigmoid and rectum; thus making it technically easier to remove.

In debilitated individuals sun-ray treatments have been found to increase general muscular tone and to produce a feeling of well-being.

Cancer of the rectum continues to present

3. Morton: S. G. & O., Vol. 66, April, 1938, pp. 769-773.

the vital problem of adequate surgical treatment, and the universally natural dread of colostomy. The literature abounds with various procedures originated to insure against recurrence of the growth either locally or metastasizing to neighboring or distant lymph nodes, and to preserve the sphincter ani muscle. We know of no other diseased organ that requires a more thoughtful individualization as to surgical procedure than does cancer of the rectum. To increase the operability and to diminish the mortality no one operation is applicable to all cases.

There are three avenues of approach:

1. Through the abdomen for the low rectosigmoidal growths.

2. Through the posterior pelvic wall by removal of the entire coccyx and part of the sacrum.

3. By the perineal route.

Combinations of these three various approaches have been utilized. The Miles operation¹ of first attacking the growth through an abdominal approach and later at the same stage, going through a perineal wound and removing it, has many advocates in this country.

Colostomy and posterior resection after the method of J. P. Lockhardt-Mummery has been utilized particularly in the old age group. There is a dispute between the advocates of the combined abdomino-perineal resection of Miles and the posterior resection of Lockhardt-Mummery over the relative merits of the respective procedures. Both are admirable methods when used at the right time.

When all is considered as to procedures, the strongest argument for the Miles operation is that it alone allows adequate removal of the zone of lymphatic spread, and unquestionably the perineal proctectomy will result in a minimum operative mortality.

We have three technical suggestions to offer:

1. In order to guarantee an adequate amount of peritoneum with which a new pelvic floor may be securely constructed without tension, we have distended the urinary bladder with saline by means of a catheter in the

urethra. This facilitates the stripping up of the peritoneum overlying the bladder and thus a large, fairly thick flap of bladder peritoneum may be obtained.

2. We have made certain that, in drawing to the midline for pelvic floor closure, the right flap of pelvic peritoneum, no angulation of the terminal ileum occurs (Lane kink) as on one occasion an intestinal obstruction resulted. Dr. Samuel Harvey, of New Haven, has also experienced such a complication.

3. Following a suggestion of Cattell, we have closed almost completely the perineal wound, leaving a small-sized rubber tube sutured at the upper angle through which 1-1,000 iodine solution twice daily irrigates the dead pelvic space killing out saphoritic organisms and promoting healing. Convalescence has been markedly shortened. Recently we have had a male patient sit out of bed with comfort on his twenty-first day post-operative.

Radium has a definite, although limited, use in the treatment of cancer of the rectum. Many tumors at the anal opening, or just within the anal opening, particularly if they are of small size, have been cured by this means. The profuse bleeding of accessible tumors has been admirably controlled by radium. In the extensive, accessible growths the implantation of radium seeds as a preliminary method for the purpose of shrinkage has been of value. As a preliminary to colostomy and posterior resection we have, upon several occasions, used this method.

POST-OPERATIVE CARE

In no other group of surgical patients, except perhaps those after operations on the stomach, should more meticulous post-operative care be taken than in cancer of the rectum. During and immediately after the operation, whether it be a finish of a one- or a two-stage procedure by the abdominal, parasacral, or perineal route, *transfusion of blood* is indicated. We are of the opinion that direct transfusions are more helpful. The patient is kept warm, the foot of the bed is elevated, and 2,500 or 3,000 c.c. of intravenous fluid are administered several days thereafter.

After an operation necessitating colostomy, there is an effort made to keep the colostomy closed for forty-eight hours before releasing the clamp. When the posterior wound is sutured and a tube left in the tip of the coccyx for irrigations, the irrigation is begun on the third day post-operatively, using 1-1,000 iodine solution.

To nourish these patients, it seems best to rely upon intravenous feeding and small sips of hot water. Early insertion of a Levine tube into the stomach is rewarded generally by the patient avoiding distention. Irrigations through the perineal wound should be done twice daily. If iodine is irritating, warm saline solution is found to be soothing.

The instruction to the patient for the care of his colostomy is of the utmost importance, and it is well to see that these unfortunate people have all of their questions concerning the care of this opening answered thoroughly. It has generally been the practice that the after-care was delegated to assistants and assistant residents; but it is my firm belief that the operator's responsibility does not, by any means, end at the close of the operation. As a matter of fact, the greatest trial which he has to bear is to try to convince the patient that colostomy, if rightly handled, will not be an unbearable nuisance.

COMPLICATIONS

1. Post-operative shock.
2. Peritonitis.
3. Atelectasis.
4. Pneumonia.
5. Wound infection (abdominal).

6. Evisceration.
7. Ileus—Mechanical obstruction
Band
Volvulus
Herniation through pelvic floor.
8. Embolism.
9. Phlebitis.
10. Parotitis.
11. Persistent perineal sinus formation or secondary perineal abscess formation.
12. Cystitis and secondary ascending renal infection.

ROOSEVELT HOSPITAL STATISTICS

1928-1938 (INCLUSIVE)

Total of 91 cases.

34 inoperable.

57 operable.

Operability 61 per cent.

12 operative deaths.

Operative mortality 21 per cent.

17 one-stage Miles operation—with three operative deaths.

Operative mortality 17.6 per cent.

28 two-stage abdomino-perineal operations with seven operative deaths.

Operative mortality 25 per cent.

6 perineal resections—with two operative deaths.

Operative mortality 33.3 per cent.

FOLLOW-UP

Of these 57 patients operated upon, 45 survived operations.

*15 lived less than one year

9 lived more than one year

7 lived more than two years

4 lived more than three years

5 lived more than four years

5 lived more than five years

* Note: Five of the 15 counted as dead because they could not be traced.

NASAL HEMORRHAGE ORIGINATING IN THE MAXILLARY SINUS

By RALPH J. VREELAND, M.D., Paterson, N. J.

So far as I have been able to ascertain no one has thought of the maxillary sinus as the source of bleeding in nasal hemorrhage in which the bleeding point could not be ascertained.

That at least, was my position up to May, 1940. At that time a man was referred to me because of severe epistaxis. The bleeding would stop suddenly for no accountable reason and without reference to any particular treatment. The man, 55 years of age, was diabetic. Though almost exsanguinated, he was not bleeding at the time and I was unable to find any source. I had him lie down and told him to notify me the moment there was bleeding. In a short time he called. Blood was pouring from his nose. By continuous suction with a fairly large tip I was able to clear his nasal cavity completely.

This blood was coming from under the middle turbinate. I felt a strong likelihood that this was from the maxillary sinus. I inserted a trocar and cannula into the maxillary sinus. The moment I withdrew the trocar, blood ran freely from the cannula. I was sure this was due to free bleeding because I had never seen blood pour out of the cannula following its use for other reasons. I inserted a suction tip through the cannula but was unable to clear the sinus sufficiently to get a clear view with the antrascopes. Then I packed the sinus through the cannula with very fine gauze moistened with adrenalin solution. The bleeding stopped and there was no further bleeding. A week later I removed the packing and irrigated the sinus gently with saline solution. After I had gotten it clean I inserted the antrascopes and discovered a large mass.

As a result of this, I believed it possible that in certain other cases of severe epistaxis in which I had been unable to find the bleeding point, the origin of the hemorrhage might be in the maxillary sinus. Since that time I have had two similar cases. Both were in adults over 55 with similar histories and similar local conditions. The last case was seen by me May 23rd, 1941. This patient was a woman 73 years of age.

The first patient was advised to have the mass removed. This was subsequently done in a New York hospital, and in a letter which I have received from the patient he described the mass as being of the same size and location as seen by me through the antrascopes.

The second and third cases have not yet sufficiently recovered to warrant operation, but they have both signified their desire to have the mass removed.

I have heard of a prominent New York physician who needed a ligature of the carotid artery to stop a nasal hemorrhage, and of a similar case in Philadelphia. In view of these cases, is it not probable that one or both of these have similar conditions?

These cases emphasize the fact that we must not overlook the maxillary sinus as the place from which the blood is coming in nasal hemorrhage in which we fail to find the active bleeding point.

There is no question about the desirability of finding the bleeding point in any case of epistaxis. If nasal hemorrhage should have its origin in the maxillary sinus it would be better to know of it and easier to take care of than by ligature of the carotid or other difficult procedures.

ATROPHIC RHINITIS

By C. COULTER CHARLTON, M.D., F.A.C.S., Atlantic City, N. J.

Read before the Eye, Ear, Nose and Throat Section of The Medical Society of New Jersey at its Annual Meeting in Atlantic City, N. J., June 6th, 1940.

When speaking of atrophic rhinitis in otolaryngology, we generally think of the type that is associated with ozena. In this paper I wish you to think only of that variety in the points I am going to bring to your attention. The disease, atrophic rhinitis, or symptoms from other causes, has been known for almost a century, and no doubt many years before that time. For years, it was often associated with tuberculosis and lues but, with the advancement of our laboratory findings, it was finally proved to be a separate clinical entity.

Numerous other diseases, such as chronic sinusitis, foreign bodies, leprosy, post-operative conditions, and diphtheria, have been associated with it.

ETIOLOGY

The etiology of atrophic rhinitis with ozena has not been determined to the satisfaction of our profession. Diseased tonsils and adenoids were thought, at one time, to be responsible. Then, later, chronic infections of the sinuses were considered the main contributing cause. Perez described the coccobacillus which he thought to be the cause, but transmission from one person to another has not been accomplished.

It has been suggested that mal-development of the bony structures of the skull may play a prominent part. Only lately Mortimer, Wright and Collip¹ from their studies found certain cranial abnormalities existing in 80 per cent of the cases examined.

They found one family in which mother, father, and nine children all were suffering from atrophic rhinitis and ozena. They came

to the conclusion that constitutional factors in the disease may be related to disturbance of the pituitary function, either as a familial characteristic, or in the affected alone.

Miller and Cocks² found that over 50 per cent of persons inhaling the moist heat while working over the mangles in laundries had atrophic rhinitis and ozena. In my investigation³ of the laundries where I am located I examined 286 persons who had been engaged in their work for an average of nine plus years, some working for over twenty years, others working over thirty years, and to my surprise, I did not find a case. My conclusion was that the climatic environment at the seashore was responsible for the difference.

Starling,⁴ writing on "The Fluids of the Body", brought out that filtration of the fluids into interstitial environment from the capillaries was by hydrostatic pressure, and that the reabsorption of the fluids was by colloidal osmotic pressure of the blood serum. Interstitial fluids which come from the blood serum are made up mostly of sodium chloride and sodium bicarbonate. When there is an excess of these sodium salts in the system, there is an increase of interstitial fluids or edema. This is just the opposite of what we have in atrophic rhinitis and ozena; and therefore, is it not conceivable that a reduction of sodium salts may be responsible for the condition?

Harrop and Weinstein⁵ have proved that dogs who have had their adrenal glands removed could be kept alive by administering adrenal cortex extract; but if it was stopped, they had a marked drop in the blood sodium and at autopsy no pathologic findings could be demonstrated. When the sodium was greatly decreased in the blood, there was an increase in the urine.

Loeb⁶ in his studies found about the same as Harrop and Weinstein, and suggested that the adrenal cortex may be the regulator of sodium metabolism.

1. Mortimer, Wright and Collip: Effects of Estrogenic Hormones on Nasal Mucosa. Canadian Med. Assn. Jour., 35:615, 1936.

2. Miller, J. A., and Cocks, G. H.: The Effects of Changes in the Atmospheric Condition upon the Upper Respiratory Tract. Tr. Am. Climat. & Clin. Assn., 31:31, 1915.

3. Charlton, C. Coulter: Climate and the Upper Respiratory System. Arch. of Otolaryn., 26:1-8, 1937 (July).

4. Starling, E. H.: The Fluids of the Body. Herter Lectures, N. Y. W. T. Keener & Co., Chicago, 1909.

5. Harrop and Weinstein: Studies on Suprarenal Cortex. Jour. Exper. Med. 57:305, 1933.

6. Loeb, R. F.: Jour. Exper. Med., 57:775, 1933.

CLIMATE

Dr. W. J. Humphreys⁷ of the United States Weather Bureau in his presidential address to the American Meteorological Society pointed out that:

"With every breath we inhale a million of micro-sticks-and-stones and a host of other things that are no part of a pure atmosphere. Where do they come from? The heavens above and the earth beneath. Every wind that sweeps a desert catches up tons, and sometimes millions of tons, of pulverized rock to spread far and wide. Fragments of vegetable fiber litter the soil the world over, and are wafted hither and yon as even the greatest breeze that may blow. Pollen of conifers, rag-weed, and a thousand other trees and plants we must take into our lungs from Spring to Fall every day we breathe the open air. And our bronchial tubes need chimney sweeps (luckily provided by nature) to get rid of their coatings of soot from kitchens, factories, and forest fires. Even the ocean, through its evaporated sprays, makes a salt mine of the air we breathe."

The thyroid gland⁸ appears to be exceedingly susceptible to climatic conditions. The greater content of iodine in the seashore air and in the food from flooded districts of the seacoast has doubtless an influence on this organ. Children with deficient thyroid glands are much benefited at the seashore. Since it is known that the seashore has an influence on the endocrine system, would it not be possible that the continuous inhalation of the moist sodium-laden air would aid in making up for the deficiency in the sodium metabolism?

Atrophic rhinitis and ozena are not seen in people who have spent their entire lives at the seashore in my locality. In talking to physicians who have practiced over fifty years in Atlantic City, they say their observations have been the same as mine concerning the rarity of the disease at the seashore. The cases that are seen are in patients that have come from other places; and after living in our community for a few years, all of the disagreeable symptoms clear up and their noses become moist.

Harold Williams⁹ states that our city has the most equable climate, and resembles more nearly that of the ocean as is experienced on shipboard, than does any other place along the Atlantic Coast. It also has the maximum

amount of oxygen, the maximum amount of aqueous vapors, the maximum amount of ozone, and small saline particles,—iodine and bromine; it presents more regular variations of barometric pressure; and it presents the minimum diurnal variations of temperature of any place along the coast.

TREATMENT

There have been a great number of methods brought forward to lessen the space in the nasal cavities thinking that would greatly improve the disease. However, most of them have had but little success.

Dr. Wagers¹⁰ has been able to demonstrate, by injecting normal saline solution into the submucosa along the whole length of the lower turbinates and at opposite points on the septum, that there was improvement of the pathologic condition of the tissues of these patients. The improvement of his cases may have been due to the increase in sodium metabolism.

Of late years atrophic rhinitis and ozena have not been as prevalent as they were some thirty-odd years ago. When I first came to the seashore I was greatly impressed by the rarity of the cases seen in the clinics as there had been so many in the large cities at that time.

It is interesting to note that sea-bathing seems to help these patients. I have often had people suffering from atrophic rhinitis tell me that getting the sea-water up their noses did them more good than anything else they had ever used. From hearing that statement so many times during the summers from visitors I decided to try using it in the office. I can state that it cleanses and stimulates the mucous membranes more than any other solution I have ever used. There are no doubt properties in sea-water that have a beneficial effect that you do not get in a normal saline solution.

The past three years I have been interested in the treatment of atrophic rhinitis with estrogenic substances, as suggested by Mortimer,

7. Humphreys, W. J.: Pres. Address, Bul. Am. Meteo. Soc., 1930 (Feb.).
8. Haberlin, C.: Treatment of Children at the Seashore. Brit. Med. Jour., Vol. 2, 1931.
9. Williams, H.: Nantucket and the Ocean Climate. Trans. Am. Climat. and Clin. Assn., Vol. 17, 52-54, 1901.
10. Wagers, A. J.: Atrophic Rhinitis. Penna. Med. Jour., 1938 (March).

Wright, and Collip.¹¹ I have found nothing, as a local treatment, that will clear up crust formation as rapidly as the estrogenic spray. However, the few cases I have had under my care with this treatment have not been observed long enough for a fair evaluation of the end results.

In our clinic at the Atlantic City Hospital, which has averaged over 1200 new cases yearly for the past twenty years, we have seen only a few cases, and they were from the out-of-town people. The private patients I have had, who have moved to our city to make it their permanent home, have been observed for ten or more years. Some have entirely lost the crust formation and odor within five years, while none have exceeded eight years.

CONCLUSIONS

From my records, as well as hospital records, it is my firm belief that atrophic rhinitis with ozena must be caused by imbalance in the biochemistry and endocrines of the system. The climatic conditions at this location, with its air laden with iodine, bromine, and saline substances, together with an abundance of sunshine, does influence the endocrine system, and it seems to improve these cases as well as aid in preventing people from developing the disease.

11. Mortimer, Wright and Collip: Atrophic Rhinitis. *Canad. Med. Assn. Jour.*, 37:445-456, 1937 (Nov.).

Biopsies of the mucous membranes taken from patients over a period of years seem to show improvement of the pathologic tissues even though no treatment has been administered. However, there has not been any return of the cilia.

SUMMARY

1. The seashore environment seems to have an influence on the people who have spent their lives here so they do not develop atrophic rhinitis.
2. If the deficiency in sodium metabolism is responsible for the atrophic membranes in this disease, I can see why persons continuously inhaling the moist sodium-laden air in Atlantic City are greatly benefited.
3. Since it is known that the endocrine system is greatly influenced at the seashore, that may be the reason these patients are improved.
4. Biopsies taken over a period of time seem to show that the mucous membranes have established better function, but without any return of cilia.
5. Irrigations with sea-water help these cases more than does plain saline solution.
6. The mineral intake from the seashore environment may also be responsible for helping cases of atrophic rhinitis, and protecting people living here from the disease.

124 South Illinois Avenue

THE PRIMARY TUBERCULOUS COMPLEX

The "primary tuberculous complex", as designated by Ranke, Parrot and Ghon, is generally understood as a local lesion or scar in direct relation to similar lesions along the course of the lymphatics towards the blood stream. This early lymphatic progress of the disease is so constant in experimental animals that it has been called the "Parrot law of similar adenopathies". It has also been considered

the same for first infections in human beings. So far as most childhood infections are concerned this is true, but variations of dosage and age of the individual may cause such an alteration of the picture that it is not always recognized by pathologists and scarcely at all by roentgenologists and clinicians.—Henry Sweaney in *The Journal of the Michigan State Medical Society*.

PUERPERAL SEPTICEMIA AS A CAUSE OF MATERNAL MORTALITY IN NEW JERSEY

MATERNAL WELFARE ARTICLE NUMBER SIXTY-TWO

By ARTHUR W. BINGHAM, M.D., East Orange, N. J.

Chairman, Committee on Maternal Welfare of The Medical Society of New Jersey; and
Chief Advisory Obstetrician, Bureau of Maternal and Child Health,
State Department of Health.

This is the second article on New Jersey Maternal Mortality Statistics.

Prior to 1933 puerperal septicemia and septic abortions were grouped together for statistical purposes. Since then, they have been classified separately. The solid line in the graph (Fig. 15) shows the mortality rate for puerperal sepsis for the State. The dotted line shows the rate for the rural counties, and the dashes, for the urban counties.

In 1940, 58,618 live births occurred in New Jersey. Maternal mortality rate for sepsis was 4.2 per 10,000 live births. For 51,620 live births in urban counties, the sepsis death rate was 3.8. Among 6,198 live births in rural counties, the rate for sepsis was 7.1 per 10,000.

For comparative study the map (Fig. 5) is prepared on a three-year basis as there is great variation in the number of births in the different counties.

Of the 25 deaths in this group, two were in colored and 23 in white patients. Fourteen were primipara, nine multipara, and two not stated. Ages ranged from 19 to 39 years.

Five were free ward patients delivered in hospitals, three of whom had received prenatal care in clinics starting in their fifth and sixth months; 2 had had prenatal care from private physicians starting with third and sixth months. Two were "ward pay" patients who had received prenatal care from private physicians. There were 3 home deliveries and prenatal care was not mentioned in the histories. Two of the home deliveries were admitted to hospitals as free ward patients the day after delivery with pyelitis. One was sent to the hospital because of puerperal sepsis.

Fifteen were private hospital patients who had had prenatal care; one began in her first month, four in their second month, five in the third month, one in the fifth month, and four case histories stated "some prenatal care". One

of these private patients was delivered and died in a maternity home.

One was positive for syphilis, 17 negative, and seven histories made no mention of it.

The periods of gestation varied from 18 at term, one at 8½ months, two at 7½ months, to four at seven months. Average length of time from date of delivery to date of death was 26 days. Two patients died 2½ months post partum.

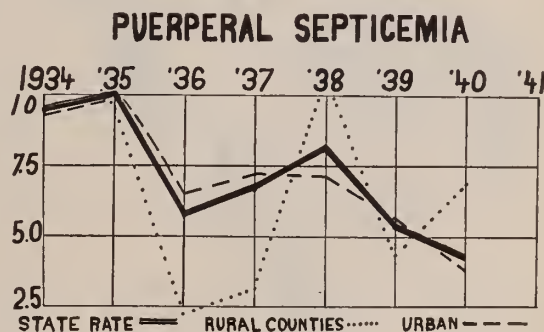


FIGURE 15

LENGTH OF LABOR

Five cesareans had no labor. Two histories did not state length of labor. Five histories stated normal labor. One had 4½ hours of labor, one had eight, and one had ten hours' labor. The prolonged hours, nine in number, varied from 30 hours to five days.

RUPTURE OF MEMBRANES

In only three cases was rupture of the membrane indicated. One read: Early rupture of membranes, prolonged labor, and cesarean. This was a free ward primipara with deformed pelvis. She had attended a clinic. No abnormalities were noted. The baby was born alive.

A second patient insisted on going home after membranes had ruptured. She was a

PUERPERAL SEPTICEMIA

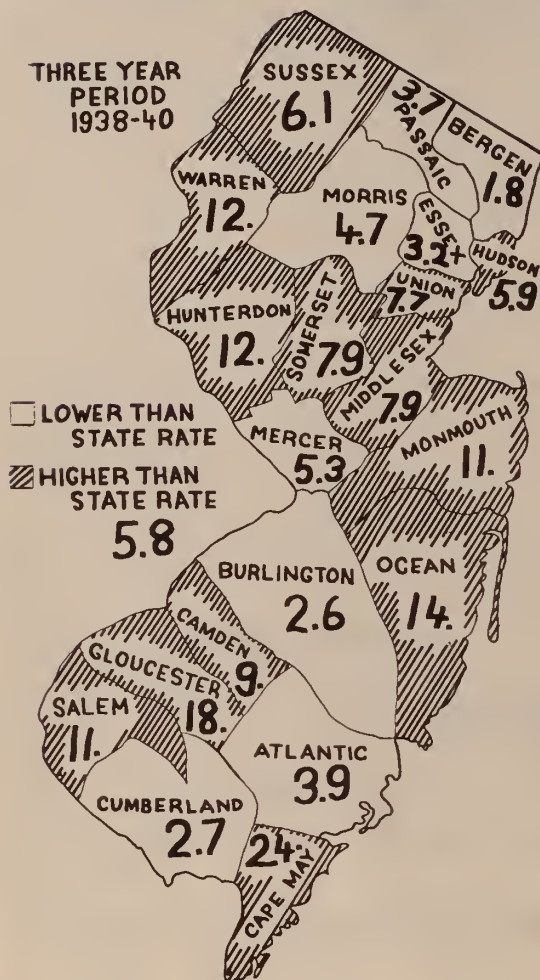


FIGURE 5

free ward patient, a multipara. Placenta was expelled one hour 45 minutes after normal delivery. Autopsy showed laceration of bladder, and macerated foetus. Gestation period was nine months.

The third patient was a primipara, in labor 48 hours later. There was early rupture of membranes. A low forceps delivery resulted in a live baby.

INDUCTION OF LABOR (1)

One "ward pay" patient had labor induced for placenta previa. Delivery occurred two days later, by version and breech extraction.

Pelvic abscesses developed three weeks later. The baby survived.

NORMAL DELIVERIES (6)

There were three home deliveries in this group.

1. Pyelitis. No prenatal care. Multipara. Age 19 years. Seven months' gestation. No physician in attendance at delivery. Slight post partum hemorrhage. Autopsy showed pyelitis, tuberculosis, and some toxemia. Stillbirth. Died 13 days post partum.

2. Pyelitis. No prenatal care. History did not state number of pregnancies. Age 25 years. Delivered before physician arrived. Hospitalized next day because of pyelitis. Seven and one-half months' gestation. History did not state if baby lived. No autopsy. Died 17 days post partum.

3. Prenatal care not stated. Multipara. Age 30 years. Nine months' gestation. Normal delivery. Not stated if baby lived.

4. Free ward hospital patient. Multipara. Age 25 years. Nine months' gestation. Left hospital against advice after membranes had ruptured. Adherent placenta. Patient had attended prenatal clinic. Macerated foetus. Autopsy revealed lacerated bladder.

5. Private patient delivered in hospital. Multipara. Age 35 years. Nine months' gestation. Normal length of labor. Developed psychosis on eighth day followed by septic temperature. Had curettage to drain pus. Live baby.

6. Private patient delivered in hospital. Multipara. Age 35 years. Term gestation. Length of labor not mentioned. Developed thrombophlebitis. Live birth.

LOW FORCEPS DELIVERIES (4)

1. Primipara. Private patient delivered in hospital. Age 21 years. Prenatal care started in third month. Gestation at term. Length of labor 4½ hours. Eighth day post partum developed psychosis and septic temperature. Septicemia finally affected heart. Live baby. Died 2½ months post partum. No autopsy.

2. Primipara. Private patient delivered in hospital. Age 25 years. Prenatal care began in second month. Period of gestation: nine

months. Length of labor: 48 hours. Premature rupture of membranes. Chills and fever started six hours post partum. Blood culture negative. Five vaginal examinations and one rectal. Died two months post partum. Live baby. No autopsy.

3. Primipara. Private patient delivered in hospital. Age 23 years. Prenatal care began in first month. Period of gestation: term. Length of labor: 10 hours. Second degree laceration. Religious obsessions developed fourth day post partum. Severe psychosis and fever with sore throat began fifteenth day post partum. Died one month post partum. Live baby. No autopsy.

4. Primipara. Private patient delivered in maternity home. Age 23 years. Had some prenatal care. Term gestation. Prolonged labor. Laceration repaired. Died 24 days post partum. Live baby. No autopsy.

MID FORCEPS DELIVERY (2)

1. Primipara. "Ward pay" patient. Age 25 years. Had had some prenatal care. Admitted to hospital five days before delivery. Rise in temperature started two days before delivery. Many rectal examinations. Period of gestation: term. Large baby. Stillbirth. Labor 48 hours. Cervix dilated manually. Died 15 days post partum. Autopsy showed pelvic abscess.

2. Primipara. Private patient. Difficult delivery in hospital. Age 26 years. Prenatal care started at two months. Term gestation. Labor 30 hours. Deep laceration repaired. Unable to void for ten days. Frequently catheterized during labor. Live baby. Autopsy disclosed puerperal sepsis, left pyonephrosis, nephrectomy; multiple cortical abscesses and gangrenous interstitial cystitis.

VERSIONS (2)

1. Multipara. "Ward pay" patient. Version because of placenta previa and profuse hemorrhage. Breech delivery. Live baby.

2. Primipara. Private patient. Hospital delivery. Version and forceps delivery attempted after 40 hours' labor. Bandle's Ring. Albuminuria. Cesarean. Stillbirth.

BREECH DELIVERIES (1)

1. Multipara. "Ward pay" patient. Delivery in hospital. Age 25 years. Prenatal care since fourth month. Gestation seven months. Antepartum hemorrhage at home. Packed. Repacked at hospital. Later, labor induced. Length of labor not mentioned. Version and breech delivery. Chill and fever fifth day post partum. Died one month later. Live baby. No autopsy.

SEVERE LACERATIONS (4)

1. Multipara. Normal delivery. Lacerated bladder.

2. Primipara. Low forceps. Second degree laceration.

3. Primipara. Difficult mid forceps delivery.

4. Primipara. Low forceps delivery.

PLACENTA PREVIA (3)

1. Multipara. Age 35 years. Gestation seven months. Hemorrhage. Cesarean. No labor mentioned. Stillbirth.

2. Multipara. Age 35 years. Gestation seven months. Profuse hemorrhage at home. Packed. Repacked in hospital. Version and breech delivery apparently two days later. Live baby. Chills and fever fifth day post partum. Pelvic abscess three weeks post partum.

3. Primipara. Age 25 years. Gestation $7\frac{1}{2}$ months. Toxic. Pyelonephritis. Cesarean. Live baby. Autopsy.

HEMORRHAGE (4)

Eighteen histories stated "no hemorrhage". In two histories, no mention of hemorrhage was made. Three patients with placenta previa had hemorrhages, as did one case of premature separation of the placenta. This patient was toxic. There was one slight post partum hemorrhage in a home delivery. No physician was present. Patient had pyelitis, tuberculosis, toxemia. Stillbirth.

TOXEMIAS OF PREGNANCY (8)

Seventeen histories of puerperal sepsis reported no toxemia. The following eight patients had some toxemia:

1. Private patient. Primipara. Age 34

years. Gestation nine months. Prenatal care began in second month. Albuminuria and eclampsia. Blood pressure 170/80. Delivery attempted after 40 hours' labor. Cesarean. Stillbirth. Patient died five days post partum.

2. Primipara. Private patient. Age 38 years. Gestation seven months. Blood pressure 150/90. Good prenatal care. Premature separation of placenta. Hemoglobin: 5 per cent. Stillbirth. Cesarean. Died five days post partum.

3. Multipara. Free ward patient. Age 19 years. No prenatal care. Lived in city. Clinics available. Normal delivery. Physician not called in time to attend delivery. Sent to hospital next day. Had some toxemia, pyelitis, and tuberculosis. Slight post partum hemorrhage. Seven months' gestation. Stillbirth. Died 13 days post partum. Autopsy.

4. Multipara. Private case. Age 36 years. Prenatal care started in third month. Blood pressure 150/100. Elective cesarean because of fibroid uterus, toxemia, and history of previous long labors. Nine months' gestation. Died six days post partum. Live baby. No autopsy.

5. Primipara. Private case. Age 39 years. Prenatal care since first month. Toxic four days and then elective cesarean was performed. Eight and one-half months' gestation. Died six days post partum. Live baby. No autopsy.

6. Primipara. Private case. Age 25 years. Prenatal care beginning second month. Patient had refused therapeutic abortion early in pregnancy. Gestation 7½ months. Pyelonephritis. Placenta previa. Elective cesarean. Died 19 days post partum. Live baby. Autopsy disclosed a pelvic abscess.

7. History did not state whether there had been previous pregnancies. Private patient. Age 39 years. Nine months' gestation. Prenatal care began in fifth month. Weight increased from 154 to 178 pounds. Blood pressure rose from 140/90 to 160/92. After eight hours' labor with no progress, cesarean was done. Post operative infection developed. Stillbirth. Patient died five days post partum. No autopsy.

8. Primipara. Free ward patient. Age 22 years. Nine months' gestation. Clinic patient. Gained 53 pounds. Albumin three-plus. She

had been in labor 48 hours with no progress. Cesarean. Peritonitis and pneumonia. Stillbirth. Died 11 days post partum. No autopsy.

CESAREANS (12)

There were two cesareans for placenta previa.

1. Multipara. Age 35 years. Free ward case. Seven months' gestation. Treated for menopause in sixth month. No labor. Stillbirth. Post partum infection. No autopsy.

2. Primipara. Age 25 years. Private case. Gestation 7½ months. Prenatal care began in second month. No labor. Live birth. Autopsy showed pyelonephritis, one small cortical abscess, free pus in pelvic cavity, and congenital heart disease. She died 19 days post partum.

In three other cesareans, patient had no labor.

1. Primipara. Private case. Age 39 years. Prenatal care throughout pregnancy. Cesarean done because of four days of toxemia. Live baby. No autopsy.

2. Multipara. Private patient. Age 36 years. Prenatal care began in third month. Nine months' gestation. Cesarean done because of fibroid uterus, toxemia and history of previous long labors and normal deliveries. Live birth. No autopsy.

3. Primipara. Private patient. Age 35 years. Prenatal care began third month. Gestation: term. Contracted pelvis was the reason for the elective cesarean. Diagnosis confirmed by x-ray. Live baby. Post partum infection. Died eight days post partum. No autopsy.

One cesarean case had a history of premature separation of the placenta with evidence of internal hemorrhage following "some labor". She was a primipara, aged 38, a private patient. Gestation: seven months. Blood pressure 150/90. Good prenatal care. Hemoglobin 45 per cent. Post-operative infection. Stillbirth. No autopsy.

In one private case, the cesarean was done after eight hours of labor with no progress. History did not state if there had been any previous pregnancies. Reasons for operation were multiple fibroids, no progress, and toxemia. Stillbirth.

Five cesareans followed prolonged labor.

1. Primipara. Age 29 years. Had attended prenatal clinic. Membranes ruptured early. About three days of labor. Nine months' gestation. Stillbirth.

2. Primipara. Private case. Age 34 years. Labor 40 hours. Gestation: term. Prenatal care began in second month. Albuminuria. Blood pressure 170/80. Patient given pitocin after 36 hours' labor for weak pains. Attempted version and delivery. Bandles' Ring. Post-operative infection. Stillbirth. Very large baby. Patient died on fifth day post partum. No autopsy.

3. Primipara. Private case. Age 24 years. Thirty-three hours' labor with no progress. Nine months' gestation. Live birth. No autopsy.

4. Primipara. Free ward case. Age 22 years. Attended prenatal clinic from fifth month. Weight increased from 168 to 221 pounds. Gestation: nine months. Forty-eight hours' labor without progress. Stillbirth. No autopsy.

5. Multipara. Free ward patient, age 32 years. Nine months' gestation. Prenatal care from private physician from her third month; she also had had visiting nurses. Labor five days at home. Bandles' Ring. Emergency operation at hospital. Stillbirth. No autopsy. Died four days post partum.

AUTOPSY

In 20 cases, there was no autopsy. In four cases, autopsies showed: (1) Lacerated bladder; puerperal septicemia. (2) Pyelitis, tuberculosis, toxemia of pregnancy, sepsis. (3) Difficult mid-forceps delivery; puerperal sepsis. And (4) placenta previa, pelvic abscess.

LIVE BIRTHS AND STILLBIRTHS

There were 15 live births in this group of 25 cases. One record did not indicate whether live or stillbirth. The stillbirths occurred in the following nine cases:

1. Placenta previa. Cesarean.
2. Macerated foetus. Retained placenta.
3. Toxemia. Premature separation of placenta, internal hemorrhage. Cesarean.
4. Toxemia. Pyelitis, tuberculosis, slight

post partum hemorrhage. Normal delivery. No physician present.

5. Toxemia. Eight hours' labor. Cesarean.

6. Toxemia. Labor 48 hours. Cesarean.

7. Albuminuria and eclampsia. Labor 40 hours. Cesarean.

8. Difficult mid-forceps delivery. Labor 48 hours.

9. Labor five days at home. Cesarean. Bandles' ring.

NEGLECT ON PART OF PATIENT

Twenty histories reported coöperation on part of patient. Five cases showed some neglect on part of patient, thus:

1. No prenatal care. Pyelitis, tuberculosis, some toxemia. No physician at home delivery. City resident.

2. No prenatal care. Home delivery. Pyelitis.

3. Psychosis developed on eighth day post partum followed by septicemia. Patient frightened by husband.

4. Ward-free patient insisted on going home on pass after membranes had ruptured.

5. Pyelonephritis. Advised to have therapeutic abortion. Refused. Placenta previa. Cesarean. Puerperal sepsis.

COMMENT

This study of maternal mortality due to septicemia brings out two points in particular:

1. *Prenatal Care.* This has not been considered an important factor in preventing sepsis; but since eight out of the 25 cases were toxic before becoming septic, preventive prenatal care manifestly has an important place.

2. *Cesarean Section.* Out of 25 deaths from septicemia 12 followed cesarean section, five of the patients having had prolonged labor. From these figures it is apparent there is an element of danger in cesarean section.

More preventive prenatal care to keep the patient in as good condition as possible, more accurate diagnosis of factors likely to complicate labor, as well as more care in carrying out aseptic technique will greatly reduce these figures.

STATE SOCIETY ACTIVITIES

ARE YOU BEING COUNTED?

When the A. M. A. calls the roll of American doctors of medicine, are you going to be counted? You will, if you return the information card sent to you earlier this month by the Directory Department of the American Medical Association. If you filled it in and mailed it, you can be certain that your name will appear in this official census of practitioners. But if you filed the card in the waste-basket, or if you never received one, please write today to the Directory Department, American Medical Association, 535 North Dearborn Street, Chicago, and ask for a duplicate information card.

The directory is prepared at regular intervals in the Biographical Department of the American Medical Association. This volume is one of the most important contributions of the American Medical Association to the work of the medical profession in the United States; it has been especially valuable in the medical pre-

paredness program. In it, as in no other directory, are dependable data concerning physicians, hospitals, medical organizations and activities. The directory provides full information concerning medical colleges, specialization in the field of medical practice, memberships in special medical societies, tabulations of medical journals and medical libraries and, indeed, practically every important fact concerning the medical profession in which any one might possibly be interested.

Before filling out the information card, read the instructions carefully. Physicians are especially urged to state whether they are on extended active duty for the Medical Reserve Corps of the United States Army and Navy. Fill out the card and return it promptly whether or not a change has occurred in any points on which information is requested. If a change of address occurs before March 1, 1942, report it at once.

IRON LUNGS IN NEW JERSEY

The National Foundation for Infantile Paralysis has compiled a list of adult cabinet-type respirators available in the United States. Only respirators approved by the Council on Physical Therapy of the A. M. A. are included. Since in an emergency, it may be life-saving to know where such respirators are available, the *Journal* publishes below the names of the institutions possessing such apparatus, in and adjacent to New Jersey. For a complete copy of all the respirators in the United States, write to the National Foundation for Infantile Paralysis, 120 Broadway, New York City.

Atlantic County: Municipal Hospital, Atlantic City. American Legion, Atlantic City.

Bergen County: Bergen Pines, Ridgewood.

Burlington County: Burlington County Hospital, Mt. Holly.

Camden County: Lakeland Sanatorium, Gretna. Cooper Hospital, Camden. Municipal Hospital, Camden. W. Jersey Homeopathic Hospital, Camden.

Essex County: Hospital for Contagious Diseases, Belleville.

Gloucester County: Underwood Hospital, Paulsboro.

Hudson County: St. Mary's Hospital, Hoboken. Jersey City Medical Center.

Mercer County: Trenton Fire Station Headquarters. Mercer Hospital, Trenton.

Monmouth County: Monmouth Memorial Hospital, Long Branch. No. 1 Phila. Blvd., Sea Girt (Spring Lake). (Harold Riley's.)

Morris County: Memorial Hospital, Morristown.

Passaic County: City Hospital, Paterson. General Hospital, Passaic.

Union County: Isolation Hospital, Elizabeth.

Manhattan (New York City): The following hospitals: Bellevue, Babies', Columbus, Gouverneur, Harlem, Metropolitan, Mt. Sinai, Presbyterian, Sloane and Willard Parker.

Philadelphia: The following hospitals: Chestnut Hill, Children's, Germantown, Hahnemann, Jefferson, Jewish, Lankenau, Misericordia, Mt. Sinai, Northern Liberties, Pennsylvania, Philadelphia General, Presbyterian, Roxborough, St. Agnes', St. Luke's, Shriners, Temple, University of Penna., and Women's Homeopathic.

In all, the Foundation lists 852 respirators, of which 26 are in New Jersey.

INSTITUTE ON PUBLIC HEALTH EDUCATION

New Jersey physicians have an exceptional opportunity to participate in a short, intensive course in the principles and techniques of educating the public in health. This Institute on Public Health Education will be held in Atlantic City, October 12, 13 and 14, just preceding the meeting of the American Public Health Association.

Included in the program of the Institute are such features as: techniques of preparing exhibits, methods of eliciting health-education participation among high school students, procedures for leading discussions, a clinic of "ex-

hibit mistakes", techniques of community leadership, methods of preparing health reports, winning support from citizens, a "printed-matter clinic", and a number of other unusual and highly practical features in this important field.

Registration fee for the Institute is three dollars for members of the American Public Health Association, six dollars for non-members. Applications for enrollment, requests for copies of the full program, and queries, should be directed to the American Public Health Association at 1790 Broadway, New York City.

OBITUARIES

DR. SAMUEL S. GIDDING

The medical profession of Southern New Jersey was shocked to hear of the untimely death of Dr. Samuel S. Gidding of Wildwood, who died of lymphosarcoma on August 12, 1941. Though only 31 years old at the time of his death, Dr. Gidding had already become a popular figure in Cape May County medical and civic circles. He was on the staff of the Atlantic Shores Hospital at Somers Point and the Jefferson Hospital in Philadelphia. He was vice-president of the B'nai Brith Association and a director of the Wildwood Chamber of Commerce.

Dr. Gidding was born in Wildwood in 1910. He was graduated *cum laude* from Lehigh University in 1930, where he won his Phi Beta Kappa key. He went on to the Jefferson Medical College, again achieving honors there by being elected to Alpha Omega Alpha. After receiving his M.D. degree in 1934 he was chosen as an intern in the Jefferson Hospital. In the summer of 1936 he returned to his native town to practice, but this was interrupted in January, 1941, when he was commissioned a Lieutenant in the United States Naval Reserve Medical Corps. He was sent to Guantanamo Bay, Cuba, where the acute symptoms of lymphosarcoma

developed. After a short period at the Naval Hospital in Philadelphia he was transferred to his home where he died.

DR. WILLIAM ERNEST RAMSAY

Long prominent in civic and welfare circles in Middlesex County, Dr. William Ernest Ramsay, honorary member of the Middlesex County Medical Society, died at his home in Perth Amboy on June 26, 1941. Dr. Ramsay had been New Jersey State Senator from Middlesex County, and for many years was Health Officer of Perth Amboy. He was a graduate of the medical college of Columbia University, class of 1888. Dr. Ramsay was born in 1866, and died of coronary embolism at the age of 74.

DR. ALVAH VERNON MILLS

Dr. Alvah Vernon Mills died on June 24, 1941, at his home in Little Falls, N. J., at the age of 59. Dr. Mills was a graduate of the medical school of the University of Vermont, class of 1905, and practiced in Newark. Cause of death was coronary sclerosis.

DECEASED PHYSICIANS — NEW JERSEY

Name	Age	Date of Death	Place of Death	Residence	Cause of Death
Imlay L. Benet	73	June 26, 1941	Orange	Maplewood	Myeloid leukemia.
Thomas J. Gallagher	48	June 30, 1941	Paterson	Hawthorne	Coronary occlusion
Frank Harris	64	June 24, 1941	Trenton	Trenton	Cerebral embolism.
Matthew A. Lenton	80	June 30, 1941	Landis Twshp.	Same	Arteriosclerosis.
William J. Lynch	52	June 23, 1941	Teaneck	Palisade Park	Ruptured gastric ulcer.
Amos J. Mander	62	June 23, 1941	Bridgeton	Millville	Chronic myocarditis.
Martin G. Marden	64	June 19, 1941	East Orange	Same	Coronary thrombosis.
Alvah V. Mills	59	June 24, 1941	Little Falls	Same	Coronary sclerosis.
William E. Ramsay	74	June 26, 1941	Perth Amboy	Same	Coronary embolism.
William R. Silverstein	58	June 21, 1941	Newark	Bradley Beach	Lung abscess.

THE IMPROVEMENT OF SCHOOL MEDICAL SERVICE

I.

First of a series of three articles prepared by the Committee on School Health of the American Academy of Pediatrics

Having made a study of medical services in the schools, the Committee warns against the misrepresentation of services, when such misrepresentation might lead to a false sense of security. They recommend a high standard of medical health supervision for children and they disapprove of school medical advice based on hasty medical judgment.

This criticism is made with full recognition that our highest standards of medical health supervision for all children cannot be achieved by any simple reform. But the Academy recommends policies necessary for schools to improve the quality of medical advice and to move forward toward the goal of first class medical health supervision for all children.

A MEDICAL RESPONSIBILITY

The first step toward better school medical service is a recognition by the public school authorities that the character of medical service in a community is a responsibility which *must* be borne by the medical profession. The work of the physician in the schools has grown up as a minor adjunct of school programs or as a neglected part of public health. It has often not been given the serious consideration it deserves.

A recognition of this responsibility was accepted by the Committee on School Health of the American Academy of Pediatrics in June, 1937, when they proposed the following five principles for guidance in the development of medical service for public schools:

1. The school medical service should be thoroughly coordinated with the other community medical facilities.
2. The advice which is given to parents, pupils, or school staff should meet the best medical standards.
3. The services of the physician in the school should contribute to sound education.

4. The examination service should provide records that are readily interpreted by those who use them, and that permit the follow-up of service to give first attention to the more serious cases.

5. The detection of defect cases should be made with economy of effort and financial cost.

More recently the American Academy of Pediatrics prepared the following statement as to "what is the least amount of medical health supervision that an average child must have to assure him of the best possible physical and mental health by the time he has reached the end of the growing period?"

1. The medical and surgical care of your child's illnesses during infancy and childhood should be the best obtainable.

The best qualified physician available should be chosen for such health supervision and care. His qualifications should be judged by the special training, experience, and understanding of child health which he possesses.

2. Your child should have regular health supervision visits for the purpose of keeping a check on his general health and growth. The minimum frequency of these visits is presented for the different age periods. Health supervision visits in school-age children should be made at least once a year.

3. Each of these health supervision visits should include the following:

- (a) A frank discussion of your child's physical and mental problems with the physician.
- (b) A physical and mental examination of your child made by the physician, with any variation from the normal recorded.
- (c) A review and discussion with the physician of your child's medical history since the last visit.
- (d) Written instructions from the physician to you concerning your child's care and diet; and recommendations for the solution of any special health problems.

Note: The Journal invites comments from readers on this report.

SUPPLEMENTARY LIST OF MEMBERS NO. 5 TO THE OFFICIAL LIST OF MEMBERS, MARCH 15, 1941

The figures in parentheses refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

ACTIVE MEMBERS

Cartisser, Joseph J., Stanhope (10)
Goldstein, Samuel M., 40 Johnson av., Newark (7)
Maxwell, Carl A., 117 Grand av., Hackettstown (21)
Messinger, Samuel, 31 Roosevelt av., Carteret (12)
Plain, Irving H., 299 Clinton av., Newark (7)

Rumage, Wm. T., 513 Sanford av., Newark (7)
Snyder, Howard P., Box 426, St. Thomas, VirginI. (18)
Wiesenfeld, Benj., 472 Rahway av., Woodbridge (12)

ASSOCIATE MEMBER

Ciccione, Edwin L., 261 Roseville av., Newark (7)

BOOK REVIEWS

Fractures and Dislocations. By Edwin O. Geckeler, M.D. Pp. 307. Baltimore, Williams & Wilkins Co. 1940. \$4.00.

This concise book consists of 307 pages including 267 figures of which 131 are x-ray pictures. It is divided into two sections, one on fractures and one on dislocations, and contains the fundamentals necessary in the diagnosing and treatment of these conditions. Written in an orderly sequence, it is easily read.

The first six chapters are confined to definitions and types, process of bone repair, complications of fractures, signs, symptoms, and aids in making the proper diagnosis, and various types of treatment including methods of reduction, means of immobilization, and follow-up therapy after immobilization has been completed.

The most commonly used types of reduction and treatment of fractures and dislocations are discussed in necessary detail and in an interesting and effective manner.

The book is ideal for the hospital internes or residents and for the general practitioner. In this day of increasing automobile and industrial accidents, the conditions discussed in this book should be part of the knowledge of every practicing physician.

JOHN J. FLANAGAN, M.D.

Pseudo-Isochromatic Plates for Testing Color Perception. 21 color plates and illustrations. Southbridge, Mass., American Optical Co. 1940. \$9.00.

This book is made up of forty-six color charts of a massic pattern of spots printed in various designs so that usually a figure or a letter will be easily discernible to the person of normal vision, but will be misread or unseen by the color-blind individual.

These plates will serve in numerous ways for the detection of even the slightest degrees of red-green color defect, as they are so arranged that they supplement each other, and since the plates are bound in book form, they are easy to handle and consume little time in routine office examination for the detection of color blindness.

These plates were originally devised for testing candidates for the army, but have since been adopted by all the leading ophthalmologic societies throughout the world. The tests can be recommended to all engaged in complete eye examinations, and especially to those examining for the army, navy, air corps, railway and marine organizations, as well as those engaged in testing individuals for licenses to drive motor vehicles.

LEE W. HUGHES, M.D.

Vitamin Therapy in General Practice. By Edgar S. Gordon and Elmer L. Sevringhaus. Chicago, Year Book Publishers. 1940. \$2.75.

Here is a detailed discussion of the various vita-

mins and accessory food factors designed to help the practitioner use his knowledge in everyday practice. There is an excellent common-sense chapter on weight control. Proteins, fats, and carbohydrates receive enough consideration to make this small volume a well-rounded summary of present-day knowledge of nutrition.

S. J. FANBURG, M.D.

A Diabetic Manual. For the mutual use of doctor and patient. By Elliott P. Joslin, M.D. 7th ed. Pp. 238. Philadelphia, Lea & Febiger. 1941. \$2.00.

This manual, which has been thoroughly revised and published this year, gives the practicing physician and the diabetic patient the benefit of the new knowledge in regard to the prevention and control of diabetes mellitus. The material presented is based on the premise that the diabetic can live long and well with a minimum of handicap in his daily adjustment if he follows the essential instructions for the control of the disease. Further hope is engendered by the inclusion of new discoveries from animal experiments which promises a renaissance in treatment.

Dr. Joslin's coverage is complete. In twenty-nine short chapters, which are intelligible to the patient, full explanations and essential instructions are given for meeting every problem that relates to the control of the disease, and social aspects are reviewed.

The manual first presents a history of the disease and its management with particular reference to the new advances in treatment brought about by the use of insulin and protamine zinc. As a result, drastic changes in diets ensued, which radically altered the course and prognosis of the disease and considerably brightened the life of the diabetic.

The book also includes complete tables of the compositions of common foods, their calculation and use. It discusses other elements of treatment which every diabetic should know, such as personal hygiene, exercise and rest, diabetic arithmetic, and the laboratory tests.

This manual is especially good for diabetics because of the hope it inspires, that they may lead a nearly normal existence, and that, if they keep the diabetes under control, they may some day reap the benefits of the research now in progress.

SELMA WEISS, M.D.

Manual of Physical Diagnosis. By Maurice Lewison, M.D., and Ellis B. Freilich, M.D. Chicago, Year Book Publishers. 1941.

All but seventy pages of this book are devoted to the examination of the heart, lungs and vascular system. It retains all of the virtues of its origin: notes from an excellent course for medical students of the University of Illinois. It is also a fine review for the general practitioner doing a little work on

the chest. Like all such efforts, it cannot replace the personal instruction and individual effort which are necessary for putting into effective use the instructions of any manual of diagnosis.

The authors properly highlight the importance of the anamnesis and "the watchful eye, the alert ear, the tactful finger and the logical mind", where laboratory methods are so largely replacing these important fundamentals of diagnosis in chest diseases.

E. P. CARDWELL, M.D.

Outlines of Industrial Medical Practice. By Howard E. Collier, M.D. Pp. 440. Baltimore, Wm. Wood-Williams & Wilkins Co. 1941. \$5.00.

The trend in industrial as in other branches of medicine is to view the patient as a whole; and it is with emphasis on this that the present book has been written. Every phase of the industrial environment, medical and non-medical, has been touched upon, the thesis being that anything that affects the health and well-being of the worker is of interest to the plant doctor. Although such a broad scope necessitates the curtailment of some of the subject matter, the author has given special consideration to problems facing the works doctor that are not often treated in texts on industrial hygiene.

The book is divided into four inter-related sections. After outlining the specifications for a well-equipped medical service, the first section considers the duties and responsibilities of the plant physician in an executive and in an advisory capacity. His relationship to the engineering and management personnel in such problems as illumination, noise, environmental and physical causes of fatigue, etc., are stressed.

The statement that "psychologic knowledge and insight are essential also for the diagnosis of the causes of accidents, industrial fatigue and labor unrest" forms the basis for the second part. Dr. Collier warns that this aspect of treatment is not easy, for the field of psychology is complex and there is no "system" of general or industrial psychology to form a background. Nevertheless, the works doctor should acquaint himself with the various theories, although the practical "common-sense" view is most useful in psychology as well as in medicine.

This section is concerned with the relationship of intelligence and personality to the worker's attitude and mental health, and their effect on work efficiency and accident-proneness. Several studies bearing on the muscular, nutritional and psychologic conditions of fatigue are discussed, with special emphasis on the industrial causes of chronic morbid fatigue. Among workers showing neurotic tendencies, long and expensive disability might be forestalled by consulting a specialist immediately following an accident, instead of waiting until litigation has begun.

The sociologic bases of illness are not neglected. For the worker, the industrial environment becomes also the place of social satisfactions. Any factors

that thwart opportunity for social expression and acceptance by the group provoke reactions that are inimical to the employees. Unrest results and the group becomes an entity when it is affected to the same extent or when it acts in unison. Unrest in the group Dr. Collier considers to be a group illness that comes within the jurisdiction of the plant doctor.

Part four, the largest section of the book, is a well-balanced discussion of industrial medicine and covers industrial poisons, dermatoses, respiratory diseases and pneumoconoses, toxic substances, and organismal and traumatic diseases of occupation.

The last four chapters are devoted to the Workmen's Compensation Acts of Great Britain, and the duties of the physician as defined in the Acts.

The author has supplied a large bibliography of recent references by both British and American writers, and there is a full index.

HENRY H. KESSLER, M.D.

Plague on Us. By Geddes Smith. Pp. 365. New York, Commonwealth Fund. 1941. \$3.00.

This interesting and instructive book is written in a form readily understood by the average layman and gives insight into the problem of epidemiology which is valuable propaganda for the physician. At the same time interesting, and apparently accurate statistics are incorporated, interspersed with historical anecdotes.

The whole is a brief but logical presentation of the "pestilential diseases" and efforts toward their control from the first available records to the present date.

First Aid in Emergencies. By Eldridge L. Eliason, M.D. 10th ed. Philadelphia, J. B. Lippincott Co. 1938. \$1.75.

This last revision by the Professor of Surgery of the University of Pennsylvania is of particular value at this time in the instruction of the many first-aid classes which are now so popular. It has a simple and complete index, is of pocket size, and is presented in a manner easily understood by the layman. It does seem in some places to be verbose.

It will be more useful as a reference work for instructors and students than as a text for simple course in first aid.

New and Nonofficial Remedies, 1941. Price: \$1.50. American Medical Association, Chicago, 1941.

Here is the real doctor's desk-book, a handy volume that will prove a time and trouble saver for the busy physician, many times a day. The ocean of new proprietaries makes it utterly impossible for any practitioner to remember the capsule-size, packaging, dosage and trade-name of the newer drugs. With NNR on his desk, however, the physician is assured of swiftly secured, reliable data on these subjects.

The book is cumulative. Each year are added descriptions of products accepted during the fore-

Books listed or reviewed in this Journal may be consulted at the Academy of Medicine of Northern New Jersey at 91 Lincoln Park, Newark.

going year. Those taken off the market or found no longer worthy of continued acceptance are deleted. Until recent years the additions and deletions have about balanced. Recently, however, the bulk of the book has been increasing and this year's volume represents the largest one ever issued.

This year's new additions include the new sulfanilamide derivative, sulfathiazole, as well as sulapyridine sodium; antipneumococcic rabbit serum of types I, II, III, V, VII and VIII; human convalescent measles serum and human convalescent scarlet fever serum; and staphylococcus antitoxin. An echo of the war is heard in the addition of shark-liver oil, which reflects the search for new sources of vitamins A and D caused by the cutting off of foreign cod-liver oil. Other newly accepted preparations are ampules of camphor, digilanid and magnesium trisilicate.

The most extensive revision is represented by the rearrangement and amplification of the chapter on serums and vaccines. This is now prefaced by a helpful index: an innovation in N.N.R. Material on vitamins and vitamin preparations for therapeutic and prophylactic use has been revised to keep it abreast of newer developments. Here, too, we find an innovation in the systematic use of graphic chemical formulas. Careful perusal will reveal minor revisions in many parts of the book made in the interest of greater clarity and in the effort to keep the book thoroughly up to date.

Reports of the Council on Pharmacy and Chemistry of the American Medical Association for 1940. Cloth. Price, \$1.00. Pp. 181. Chicago: American Medical Association, 1941.

This volume contains the published reports of the Council for the preceding year plus reports on products which were not deemed important enough to be published in *The Journal*.

There are a number of interesting reports in the "non-acceptable" category. The one on the widely exploited Neurosine of the Dios Company sounds a

timely warning on the hazards of bromidism and uncontrolled hypnotic medication. The report rejecting a number of preparations of gonadotropic hormone and ovarian anterior pituitary preparations attest the Council's continued critical interest in endocrinology. This is also indicated in the report on Desoxycorticosterone, with a statement of the Council's attitude on the present status of adrenal cortex. The Council finds adrenal cortex therapy now in an unsatisfactory and unsettled state.

Noteworthy preliminary reports are on Guanidine Hydrochloride-Calco, which has been proposed for use in the treatment of myasthenia gravis, and Acetylglycarsenobenzene, a new antisypilitic for intramuscular use, which the Council feels should be further perfected. In its report the Council comments with approval upon the manner in which the Winthrop Chemical Company has developed the latter and studied it before even considering its commercial production.

Among the nomenclature items are those designating "Pyridoxine" and "Pyridoxine Hydrochloride" for Vitamin B₆ and Vitamin B₆ Hydrochloride; "Sulfathiazole" for 2-Sulfanilamidothiazole and "Sulfamethylthiazole" for 2-Sulfanilamido-4-Methylthiazole.

Mention must be made of the excellent report on organic mercurial compounds as bactericidal agents, which states the Council's conclusion that no organic mercurial compound has yet been offered that will guarantee the destruction of spores under all conditions.

Another valuable warning is that on the promiscuous use of the barbiturates. This is a continuation of a previous study of the use of barbiturates in suicide. The present study is an analysis of hospital data.

One cannot even glance through a volume such as this without reflection on the great value of the Council on Pharmacy and Chemistry's work, which so richly deserves the support of all interested in the progress of medicine.

BOOKS RECEIVED

ESSENTIALS OF ELECTROCARDIOGRAPHY, for the student and practitioner of medicine. By Richard Ashman, Ph.D., and Edgar Hull, M.D. 2d ed. Pp. 373. New York, Macmillan Co. 1941. \$5.00.

MANUAL OF DISEASES OF THE EYE. By Charles H. May, M.D., and Charles A. Perera, M.D. 17th ed. Pp. 519. Baltimore, Wm. Wood. 1941. \$4.00.

BODY MECHANICS IN HEALTH AND DISEASE. By Joel E. Goldthwait, M.D.; Lloyd T. Brown, M.D.; Loring T. Swaim, M.D., and John G. Kuhns, M.D., with a chapter on the heart and circulation as related to body mechanics, by William J. Kerr, M.D. 3d ed. Pp. 316. Philadelphia, J. B. Lippincott Co. 1941. \$5.00.

CEREBROSPINAL FEVER. By Denis Brinton, M.D. Pp. 163. Baltimore, Wm. Wood. 1941. \$3.00.

CLINICAL IMMUNOLOGY, BIOTHERAPY AND CHEMO-

THERAPY IN THE DIAGNOSIS, PREVENTION AND TREATMENT OF DISEASE. By John A. Kolmer and Louis Tuft. Pp. 941. Philadelphia, W. B. Saunders Co. 1941. \$10.00.

HANDBOOK OF COMMUNICABLE DISEASES. By Franklin H. Top, M.D., and collaborators. Pp. 682. St. Louis, C. V. Mosby Co. 1941. \$7.50.

MICROBES WHICH HELP TO DESTROY US. By Paul W. Allen, Ph.D.; D. Frank Holtman, Ph.D., and Louise Allen McBee, M.S. St. Louis, C. V. Mosby Co. 1941. \$3.50.

SYNOPSIS OF APPLIED PATHOLOGICAL CHEMISTRY. By Jerome E. Andes, M.D., and A. G. Eaton, B.S. St. Louis, C. V. Mosby Co. 1941. \$4.00.

CARDIAC CLINICS; A MAYO CLINIC MONOGRAPH. By Frederick A. Willius, M.D. St. Louis, C. V. Mosby Co. 1941. \$4.00.

Letters to the Journal

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Letters commenting on material in the *Journal*, as well as suggestions for the welfare of the Society, may be directed to "The Editor", Medical Society of New Jersey, 143 East State Street, Trenton. The Publication Committee reserves the right to edit, reject or abbreviate any letters submitted.

EYE WASH

Dear Editor:

Referring to Dr. Leighton's article on "The Doctor as a Prescription Writer",* I agree that physicians are too prone to use proprietaries. Yet I must condemn Dr. Leighton's examination as unfair. Only a memory hack or grind could have possibly passed that examination. His examination reminds me of the old poser: "Name and bound the 48 states." To what purpose?

How can anyone remember 8 official preparations of iron, and why? Basham's mixture and Bland's pills are relics of the 19th century. Question 2 asked for a nonsensical mixture to be written in Latin. A Latin prescription strikes me as stilted. I advocate the study of Latin, but peppermint water is as pleasing to the patient as *Aquae menthae piperitae*.

Question 5 calls for a collyrium containing argyrol. If the drug houses do our thinking for us, the A. C. Barnes Co. is thinking for the State of Maine. In New Jersey we would ask for "mild silver protein", not "argyrol"—the trade name owned by Barnes.

Men coming out of school today know more than ever of the action of drugs. They can prescribe an eyewash even if they do not call it a "collyrium".

Except for the use of specifics, there is a tendency toward drug nihilism. . . . Hurrah!

MANFRED KRAEMER, M.D.,
Newark.

INSIDIOUS PRACTICE

Dear Editor:

With reference to Dr. Leighton's article,* may I submit this comment?

What irks the pharmacist is that with all the progress that has been made in the scientific treatment of disease, the physician, like the patient, insists on being fooled!

A prescription should be a direct order to the pharmacist specifying the desired drug by an official or accurate chemical title. Such a prescription could be readily filled and supplied to the patient at a reasonable cost. But manufacturers of new drugs insist on placing them in specially colored capsules or sealing the capsules in which they are dispensed with some particular seal, or exhibiting the drug in some particular type of vehicle. This causes the basic drug to assume some special significance under its fanciful title described to the physician by a glib-tongued detail man and often leads the physician to believe that the proprietary brand of the drug has properties not enjoyed by the drug itself. It is this insidious practice which has caused so much of the difficulty in supplying satisfactory medication to patients by way of the physician's prescription and has often led to self-medication because of the ease with which patients can read proprietary names on a prescription. This practice has also added to the cost of medication to the patient and has made it necessary for the pharmacist to multiply his stock of the same drug manyfold in order to meet the demands of his clientele.

Teaching prescription writing is not difficult, but such teaching should be based upon the fundamentals of clinical experience with drugs. Prescription writing should be taught when medical students are at the bedside, that is, when they comprehend the patient's need of medicine. To teach prescription writing in the first or

second year of the medical course is an unsound procedure because the medical student at that time has no particular interest in the subject, as he does not realize its important application to medical practice.

If the clinical professors in our medical schools were to undertake the teaching of prescription writing in connection with their particular specialty, the medical student would become a more competent physician and an accurate prescription writer and the patient would be better served.

ROBERT P. FISCHER, Phar. D.,
Secretary, N. J. State Board
of Pharmacy.

FROGS AND WORMS

Dear Editor:

Having delivered lectures to interns on prescription writing, I have found that to 90 per cent of the young doctors, most of the medications are unknown in color, consistency, reactions or incompatibilities. One of my interns gave the dose of croton oil as "from a half to two drachms". How absurd to give a man a license to practice without his having a thorough knowledge of the usual drugs!

I am thoroughly in agreement with Dr. Leighton* about the shortcomings of medical schools in the teaching of applied therapeutics. The student should be required to take a 3-month course in pharmacy as part of his pre-medical curriculum. Medical schools should display cannisters containing the principal drugs, so that the student may become familiar with their appearance. Intensive instruction in materia medica and pharmacy might be substituted for the dissection in zoology classes. It will be much more useful towards the scientific

*Page 351 of July *Journal*.

application of medicine than is the study of frogs and worms.

Remember that many conditions arise in average practice in which hormones, vitamins and proprietaries are not indicated, and where we could well resort to the old galenicals like Fowler's solution, columbo, gentian, nux vomica, hydrastis, henbane, and buchu.

HARRY B. EPSTEIN, M.D.,
Newark.

FANCY APPARATUS

Dear Editor:

The title of Dr. Fine's article,† "Spontaneous Traumatic Pneumothorax", is somewhat confusing. Spontaneous pneumothorax and traumatic pneumothorax are distinct entities. The great majority of spontaneous pneumothoraces occur in artificial pneumothorax for tuberculosis. Dr. Fine did not clarify this point.

The alarming symptom is due to the high intrapleural pressure. Withdrawal of the excess air to permit satisfactory lung function is all that is necessary. Few physicians carry the fancy apparatus described by Dr. Fine. A single aspiration of air may be enough. If repeated deflation is necessary, we fix the needle to the chest wall with adhesive, after the needle has been previously passed through a cork. Rubber tubing attached to the needle is passed onto a water bottle just below the level of the bed, and the open end of the tubing is just below the top of the water. This simple apparatus could be used by any physician anywhere.

If the perforation does not heal, empyema will ensue. Thoracoplasty is then the treatment of choice.

SAMUEL B. ENGLISH, M.D.,
Superintendent,
N. J. Sanatorium,
Glen Gardner.

MISLEADING

Dear Editor:

Having read Dr. Fine's article† very carefully, I regret that I must take issue with him. The title is misleading since (except for the case reports) the paper deals with spontaneous bilateral pneumothorax: an extreme rarity. It is inaccurate to refer to "air in

the chest cavity" when "air in the pleural space is meant". The theory that tuberculosis is the common cause for pneumothorax is no longer held. Most spontaneous pneumothoraces occurs in apparently well people, few of whom ever develop tuberculosis later.

The author's division of pneumothorax into "open" and "closed" types is purely academic. All cases are open until the opening is sealed and the air absorbed. And positive pressure is not usually observed except when the mediastinum is fixed or the opening is closed.

Frequently, spontaneous pneumothorax will cause little disturbance. This paper goes far beyond its title into a discussion of spontaneous pneumothorax in general. Obviously the consequence of a spontaneous pneumothorax added to an induced pneumothorax is another problem.

Dr. Fine has confused the term "lung field" with "pleural space", saying that "x-ray discloses a characteristic transparent lung field".

Finally, his procedure for withdrawing air from a spontaneous pneumothorax is ordinarily unnecessary and should be condemned except in bilateral pneumothorax, or where pulmonary compensation is impaired. Healing of the fistula is not favored by withdrawing air. This creates greater negative pressure, which by drawing in more air, further prevents healing.

His therapeutic suggestion is ingenious, and may have value in the very limited field of spontaneous pneumothorax on one side in the presence of a previously induced bilateral pneumothorax. Unfortunately, the reader is likely to get the impression that Dr. Fine's suggestions are for the victims of spontaneous bilateral pneumothorax.

It is hoped that these remarks will be received in the spirit of constructive criticism.

A. E. JAFFIN, M.D.,
Jersey City.

ELEMENT OF DANGER

Dear Editor:

Dr. Fine's suggestions† impressed me as worthy of trial, ex-

cept that I am hesitant about leaving a needle in the patient's chest to be controlled by the patient himself. In such a practice there is an element of danger: danger of the lung reëxpanding or coming into contact with the needle on increased effort; and danger of embolism through an intercostal vessel if excessive manipulation by the patient occurred. Otherwise, Dr. Fine's suggested method should meet with acceptance.

JOSEPH GORDON, M.D.,
State Hospital for
Tuberculosis,
Ray-Brook, N. Y.

IN REPLY

Dear Editor:

I am fully aware of the deflation apparatus that Dr. English describes. My device avoids the pitfalls of that method, however. How often have you noted the water bottle inadvertently dislodged by a clumsy attendant? How comfortable is the patient whose every move is limited by a few feet of rubber tubing?

In reply to Dr. Jaffin's comments: chronic pulmonary tuberculosis is the most common cause of spontaneous pneumothorax. My experience at Newark City Hospital proves this. The associated factors are caseous pneumonia, rupture of a focus through the visceral pleural, and ruptured emphysematous bleb associated with the cicatricial process of healed tuberculosis. Also, the deflation of any tension pneumothorax giving respiratory distress is essential. Whether my apparatus discourages the healing of a fistula is not the issue; any other apparatus has the same difficulty here.

I agree with Dr. Gordon that it is poor practice to allow a patient to walk about with a needle in his chest. But under extenuating circumstances, the apparatus suggested may be of value.

M. J. FINE, M.D., Director,
Tuberculosis Division,
Newark Department of
Health.

● THE BULLETIN BOARD ●

A symposium on Medical Preparedness will feature the joint meeting of the Bergen and Passaic County Medical Societies at 9:00 p.m., Thursday, September 11. The meeting will be held at Paterson School No. 13, on 22nd Street at 15th Avenue, Paterson. Speakers will be Colonel Walson, Corps Area Surgeon, who will discuss "What the Army Expects of Civilian Doctors"; Dr. Charles Schlichter, Chairman, and Dr. Norman M. Scott, Secretary of our Society's Committee on Medical Preparedness, who will analyze the work done by civilian physicians on the draft boards and discuss the doctor's rôle in national defense.

Treatment of some of the commoner dermatoses will be discussed by Dr. Henry B. Decker, Assistant Professor of Dermatology at the Jefferson Medical College, on the evening of Thursday, September 18, at the Woodbury Country Club. This will constitute the scientific program of the Gloucester County Medical Society's first fall meeting, which opens that evening at 9:00 p.m. Dr. Decker is a member of the Camden County Medical Society.

The Monmouth County Medical Society will meet September 24 at the Berkeley-Carteret Hotel in Asbury Park to hear Dr. Chester R. Brown discuss "Prematurity and the New-Born". Dr. Brown is Chairman of the Advisory Committee on Child Health of The Medical Society of New Jersey. All physicians are invited to attend and participate in this discussion which will open at 9:00 p.m.

Dr. Ralph A. Hurd, Assistant Professor of Gynecology, Columbia University, will talk on "Endometriosis" before the Section on Obstetrics and Gynecology of the Academy of Medicine on Thursday evening, October 2, at 8:45 p.m., 91 Lincoln Park, Newark.

"The Technique of Remedial Reading" will be discussed on the evening of October 13 before the Eye, Ear, Nose and Throat Section of the Academy of Medicine meeting at 9:00 p.m., at 91 Lincoln Park, Newark, N. J. Dr. Grace M. Kahrs will lead the discussion.

Major Clarence W. Way, Cape May County's representative on our Nominating Committee, has been ordered to Washington for a special course in tropical medicine.

The American College of Physicians announces its twenty-sixth Annual Session on April 20-24, 1942, at St. Paul, Minnesota. Interested physicians may secure a more complete program from Mr. Edward Loveland, American College of Physicians, 4200 Pine Street, Philadelphia, Pa.

Essex County Medical Society opens its scientific programs with a talk on the value of blood and plasma in transfusion. The speaker will be Dr. Harold Jones, Associate Professor of Medicine at the Jefferson Medical College. The Society meets at 9:00 p.m., Thursday, October 9, at the Academy of Medicine, 91 Lincoln Park, Newark.

Hypertension and other cardiovascular diseases will be the theme of the Graduate Fortnight of the New York Academy of Medicine, which will be held October 13-24, 1941. The project includes discussions, clinics, demonstrations, speeches and exhibits. A complete program may be secured by addressing Dr. Mahlon Ashford, New York Academy of Medicine, 2 East 103rd Street, New York City.

The American Academy of Ophthalmology and Otolaryngology meets October 19 to 23 at the Palmer House in Chicago. Features of this year's program include a symposium on vertigo, a discussion of otolaryngologic problems and the weather, a special "teachers section", expanded scientific exhibits, and an elaborate moving picture program. For further details, write to Dr. William P. Wherry, 1500 Medical Arts Building, Omaha, Nebraska.

Physicians are wanted by the New Jersey State Hospital at Marlboro. Two Junior Resident Physicians are needed, each of whom will receive a salary of \$1800.00 per year and maintenance. The State Hospital is also approved for residency in psychiatry and there is one vacancy for a Resident Psychiatrist, for which the stipend is \$600.00 a year and maintenance. Members who know young physicians interested in this work should advise them to communicate directly with the Medical Director of the Hospital, Dr. J. Berkeley Gordon.

The American Board of Obstetrics and Gynecology announces that the written examination and review of case histories for Group B candidates will be held at 2:00 p.m., January 3, 1942. Applications for this must be submitted to Dr. Titus before October 1st, 1941. The oral and pathologic examinations will be held in Atlantic City in June, 1942. After this year there will be only one classification for candidates, and all applicants will be required to take both examinations. For further information and for application blanks, write to Dr. Paul Titus, 1015 Highland Building, Pittsburgh, Pa.

Congress has appropriated \$1,200,000 for the training of nurses for national defense. These funds are being administered by the U. S. Public Health Service to augment the number of students in nursing education programs and in preparing graduate nurses for active duty.

WOMAN'S AUXILIARY

MESSAGE FROM THE PRESIDENT

A CALL TO SERVICE

As the Woman's Auxiliary to The Medical Society of New Jersey begins its fifteenth year as a service organization, let us underscore once more the purpose of our association as it is written in our Constitution, Article II: "The purpose of the Auxiliary shall be (1) to assist the Medical Society of New Jersey in such a manner as it may suggest or approve; (2) to promote good fellowship among physicians' families."

The Medical Society now has issued a call to service, a call that I am confident all Auxiliary members will wish to answer to the best of their abilities and in the fullest measure. On June 22nd Dr. Lewis invited your President to meet with the Executive Committee of The Medical Society of New Jersey (a rare privilege indeed) to hear discussed the complete Medical Preparedness Program for New Jersey. In his opening statement to the group assembled, President Lewis stated forcefully that "to await the actual emergency is to invite chaos and disaster". He then proceeded to outline a medical defense plan stressing particularly the part to be taken by the Woman's Auxiliary. Our duties include the organization of:

1. Emergency nursing groups to serve in emergency hospitals made up of lay members and headed by R.N.'s.

2. Operating room teams made up of R.N.'s among the membership of laity.

3. Obstetrical teams made up of lay members and R.N.'s.

4. Clerical teams—for hospital operation.

5. Emergency feeding squads, specifically for medical and nursing personnel not otherwise cared for.

6. Transportation squads, for moving equipment, personnel of hospitals. Messengers for professional staff of hospitals.

7. Welfare squads to look after the families of physicians and members of Woman's Auxiliary who are occupied in disaster relief work.

Note: It is recognized that many of the above activities parallel the work outlined by the Red Cross. Therefore, it is to be understood that the activities will be confined to the establishment, operation and support of emergency medical services.

The second duty mentioned in our Constitution, "to promote good fellowship among physicians' families", becomes especially significant to those Auxiliaries living near army camps. The Burlington County Auxiliary has already rendered real service to enlisted men at Fort Dix by contributing cookies. Other Auxiliaries in defense areas may wish to open their homes to army physicians who may be far distant from friends and relatives. These small kindnesses go far in strengthening the morale of our army.

In my opinion our opportunity to assist in New Jersey's Medical Preparedness is the greatest challenge and the highest honor that has ever come to our women. Our effectiveness as an Auxiliary this year will be largely determined by the efficiency with which we fulfill the profession's request—a request that means not only service to our organization but service to the community, state and nation. The first step in support of this project will be to fill in and return on the same day of its receipt a questionnaire that will come to you in the early fall, regarding your ability and willingness to serve in any of the capacities mentioned. When the resources of the Auxiliary have thus been surveyed, the program planned for our members can be carried out.

In addition to our defense program, we must continue to emphasize our normal Auxiliary work which produces lasting values. Public Relation activities become even more significant as the crisis brings to light personal health defects that have long been deplored by physicians. Health programs need to be presented by expert medical authorities to the various women's clubs, to which our members belong, on such subjects as Maternal and Child Welfare, Anti-Tuberculosis, Cancer, Communicable Diseases, Mental Hygiene, and Nutrition. The latter is exceptionally important in defense. Food won the World War Number I; it probably will this one.

Arts and Hobbies need to be cultivated to relieve nervous strain and tension occasioned by the war. Then, too, we must keep our ears to the ground for any destructive legislation that seeks to engulf the medical profession.

Lastly, our own philanthropy, Widows and Orphans, merits the support of every doctor's family in the State.

We have had a glorious past; let us begin an equally brilliant future by coming to our open State Board Meeting at the Hotel Walt

Whitman, in Camden, at 10 o'clock, October 13th, well informed as to our duties because we have read the *Bulletin*.

MRS. OSWALD R. CARLANDER, President,
Woman's Auxiliary to The Medical Society of New Jersey.

A special conference of the Chairwomen of the Public Relations Committees of the County Auxiliaries will be held Friday, September 26, at 11 a. m. at the State Office, 143 East State Street, Trenton.

The Past-Presidents of the Auxiliary to The Medical Society of New Jersey are reminded of the Fellowettes' meeting to be held September 15, time and place to be announced.

Mrs. A. Haines Lippincott of Camden, first President of the Auxiliary, will be the Presiding Officer.

The Executive Board of the Auxiliary to The Medical Society of New Jersey will be held in Camden at 10 a. m., October 13, at the Walt Whitman Hotel. All Auxiliary members are welcome to attend this open meeting, and all who can come to Camden that day are urged to do so.

ACADEMY OF MEDICINE

Officers of the Academy of Medicine of Northern New Jersey for the year 1941-1942 are:

President: E. W. Sprague, M.D.

Vice-Presidents: W. B. Mount, M.D., and John W. Gray, M.D.

Secretary: Franklin J. Tobey, M.D.

Treasurer: Lee W. Hughes, M.D.

Chairmen of the sections are: D. E. Kavanaugh (Surgery), Lewis W. Brown (Medicine and Pediatrics), A. Russell Sherman (Eye, Ear, Nose and Throat), and H. B. Wilson (Obstetrics and Gynecology). Secretaries of the sections are: Drs. E. A. Flynn, H. C. Crossfield, W. F. McKim and Alfred Meurlin, respectively.

Programs of the scientific sessions will be announced in the Bulletin Board in this *Journal*. (See page 490, this issue.)

During the summer extensive alterations have been in progress to join the Eagleton Civic Medical House to the Academy building. On the first floor, arches in the reading room of the Library connect the two houses, making a spacious library and reading room, thereby doubling the former space. Adjoining this is a reading and study room for mem-

bers of the Academy. Two rooms in the rear are available for reading and study. A kitchen is provided for collations. Entrance has been made from the Council Room to the other house, where an additional coatroom is being installed. This will create easy entrance to the Auditorium.

The Section Meeting Room on the second floor has an entrance to the front room of the new house where a second meeting room is planned. Other rooms on this floor will consist of a ladies' parlor and lavatory. The third floor front of the Eagleton Medical Civic House will be occupied by the Museum. Both buildings will be redecorated.

With all this innovation, it is only proper that the October stated meeting will be a "house warming" meeting.

A cordial invitation is extended to all physicians, dentists and the allied professions throughout the State to attend and bring their relatives and friends.

Dr. Howard W. Haggard, author and former professor at Yale University, will be the guest speaker. A collation will follow the meeting.

F. J. TOBEY, M.D., Secretary.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XIV

September, 1941

No. 9

TEN years ago no more than a dozen school health administrators were actively seeking out tuberculosis among the students in colleges and universities, despite the acknowledged predilection of the tubercle bacillus for those of this age group. Today 248 institutions of higher learning have some form of program for the finding of tuberculosis on the campus. The Tenth Annual Report of the Tuberculosis Committee of the American Student Health Association is both a record of progress and a reminder of what is still to be done.

FINDING TUBERCULOSIS AMONG COLLEGE STUDENTS

The colleges and universities of the United States and Canada are becoming increasingly "unfair to tuberculosis!" They are showing that they recognize an obligation to safeguard and improve campus health and the present report of the Tuberculosis Committee relates action such as no previous report has recorded.

For the academic year of 1939-40, 248 colleges had some form of tuberculosis control, an increase of about 50% over the preceding school year. Necessarily, where a movement is gaining new adherents annually, the character of individual programs varies greatly. There are still 629 colleges with no program but about 30 of these hope to initiate one this year. Although 402 schools neglected to return the questionnaire sent by the Committee, there were 193 additional replies this year. In spite of this, six states have failed to report a single collegiate tuberculosis program.

The duties of the Committee fall into three divisions: first, the presentation to interested schools of the most approved outline of workable institutional tuberculosis case finding; second, the active encouragement of interest in case finding; and third, the collection, analysis and publication of statistical data secured from colleges taking part in the national survey.

Since the statistical data collected by the Committee are submitted by many people and accumulated under widely differing conditions, some are open to criticism so the report figures are indica-

tive of trends rather than mathematical pronouncements.

The procedure is to mail questionnaires early in May to co-operating schools and a follow-up is sent in October when necessary. Nothing is asked which would require the keeping of complex records. The form requests the name and enrollment of the college, number of positive reactors to tuberculin, tuberculosis cases discovered and their disposition, and the number of students tuberculin tested and x-rayed elsewhere than on the campus. Similar data are requested on non-student tuberculosis. Returns are divided by sex. The reverse side contains questions as to procedure which, in general, can be answered by a check mark. The recommended technics are plainly underlined. A duplicate copy of the questionnaire is sent for the use of the health officer of the institution.

This year questionnaires were sent to 20 colleges and universities in Canada. There is no Canadian student health association and so frequent have been the requests for information that it was decided to circularize these colleges. Several fine programs are already under way in Canada.

More colleges have discovered this year that a relatively simple system suffices to keep track of tuberculin testing, negative and positive reactors, x-ray results, etc. It is essential that those conducting health work know, at any time, the exact status of their effort and the result.

The Committee agreed that tuberculin testing is a prime prerequisite to a tuberculosis case-finding

plan and believes that only thus can *all* infected students be identified. The Committee recommends the annual re-testing of all negative reactors since the initial infection occurring in a young adult may produce an unpredictable clinical sequence of events. Where hazards of infection are heightened, as in nursing, medicine, dentistry, practice teaching, etc., more frequent testing is indicated.

The Committee recommends that only reliable tuberculin be used and that a positive reaction to the tuberculin test be succeeded by a good chest film. Where possible, the fluoroscope should be used as a supplement to the film.

In Table I data from 166 colleges are compiled because their figures seemed satisfactory in quality. The continued shrinkage in positive reactors seems to indicate a national decline in childhood infection.

TABLE I

Tuberculin Testing of American College Students

Year	Total No. Tested	Per cent Positive
1932-33	14,318	35.0
1933-34	25,184	30.3
1934-35	26,861	29.4
1935-36	31,601	30.0
1936-37	56,224	27.3
1937-38	64,232	25.8
1938-39	82,774	25.5
1939-40*	123,389	25.4

*Reliable returns only.

The results of the survey in cases found are condensed into Table II.

TABLE II

Cases of Pulmonary Tuberculosis

Diagnosed Among College Students 1939-40

- A. In institutions with *some* tuberculosis control program
B. In institutions with *no* tuberculosis control program

	A.	B.
Clinically active cases diagnosed*	292	21
Apparently arrested cases diagnosed*	345	14
Withdrawals due to tuberculosis	273	25
Old cases back in school	338	23
Institutions reporting	248	227
Approximate total enrollment	490,000	200,000

*Generally recognized criteria of activity were specified.

Using only the active cases for comparison, it is seen that such cases were turned up with much greater frequency in Group A. It is fair to presume that these cases were found early, often pre-clinically, instead of late and with marked signs and symptoms, which proves again the importance of early diagnosis.

Educators are sensing the urgency that animates an enlightened citizenry intent on eliminating every preventable disease. The ultimate aim of the Committee is to report that in answer to their questionnaire, every American college has replied: "We have a modern tuberculosis control program, and tuberculosis will not catch this college or any of our students napping."

Tenth Annual Report of the Tuberculosis Committee, American Student Health Association, 1939-40 by Charles E. Lyght, M.D., Chairman, Journal-Lancet, April, 1941.

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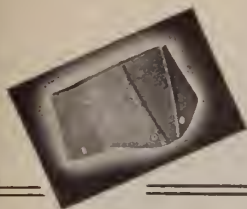


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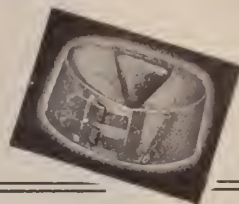
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See Page 539

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1. Knight, F., and Shelanski, H. A., "Treatment of Acute Anterior Urethritis with Silver Picrate," *Am. J. Syph., Gon. & Ven. Dis.*, 23, 201 (March), 1939.

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BURLINGTON ..	F. D. Fahrenbruch	101 Garden St., Mt. Holly	237
CAMDEN	Edmund Hessert	417 Cooper St., Camden	3382
CAPE MAY	Clarence W. Way	Fort Dix	55
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HUDSON	John J. McCarthy	616 35th St., North Bergen	Palisades 6-2385
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MERCER	James R. Harman	824 W. State St., Trenton	3-0436
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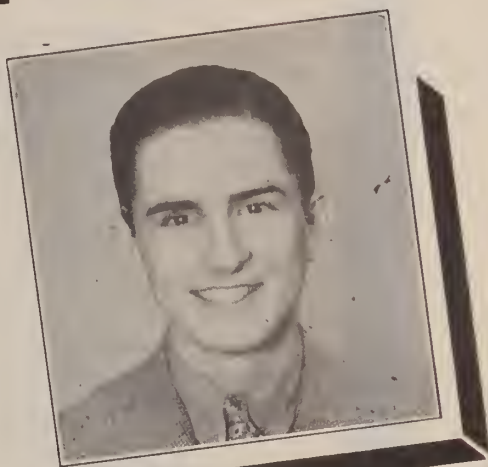
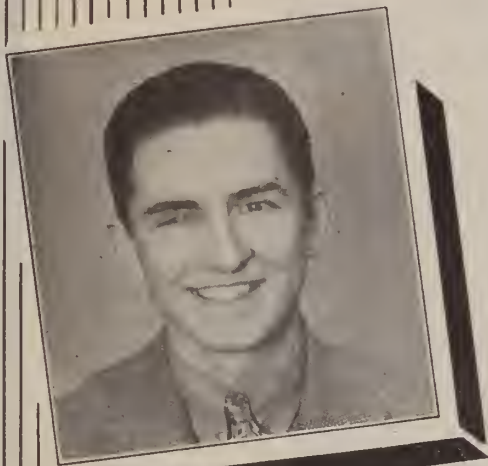
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IT IS OF VITAL IMPORTANCE TO THE PATIENT'S FUTURE APPEARANCE THAT THE FIRST ARTIFICIAL EYE BE PROPERLY FITTED. IT IS IN THESE NEW CASES, WHERE UTMOST ATTENTION MUST BE GIVEN—AND OF WHICH WE HAVE MADE A SPECIAL STUDY.

Especially Made to Order Eyes by Skilled Artisans.

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"Pleasing Particular People for Over Forty Years!"

THE NATURAL MINERAL WATERS OF SARATOGA SPA ARE
OWNED AND BOTTLED BY THE STATE OF NEW YORK



SARATOGA SPA COESA WATER

for

Poor Elimination From The Gall Bladder

This is a condition in which Saratoga Spa's Coesa Water has resulted in notable usefulness. In some patients with gall bladder conditions it has helped achieve the elimination of small concretions of a size which may pass through the cystic and common ducts.

Coesa is a mildly laxative water, antacid and diuretic, and has been found beneficial in both gall bladder and liver conditions. Because it dissolves mucus and has a generally restorative and tonic effect, Coesa is prescribed for many suffering from mild catarrh of the stomach and intestines. Experience indicates the soundness of a dosage of one bottle during the hour before luncheon and one during the hour before dinner.

As a mild laxative for some people, Coesa is taken as Hathorn is: i.e. a bottle upon arising.

Clinical literature on these and related matters is available—as is also physician's sample package of four bottles of the Waters. Address W. S. McClellan, M.D., Medical Director, 159 Saratoga Spa, Saratoga Springs, New York.

Analysis of the Three Waters

(MINERAL PARTS PER MILLION)

Hypothetical Combinations	Geyser Water	Hathorn Water	Coesa Water
Ammon. chlorid	48.25	59.10	33.30
Lithium chlorid	21.07	64.49	46.43
Potass. chlorid	361.91	789.54	714.86
Sodium chlorid	2,010.48	8,594.84	4,233.14
Potass. bromid	9.23	160.00	13.90
Potass. iodid	1.10	4.80	1.36
Sodium sulphate	None	None	None
Sod. metaborate	Trace	None	Trace
Sodium nitrate	Trace	Trace	Trace
Sodium nitrite	Trace	Trace	Trace
Sodium bicarb.	2,213.78	424.71	1,331.15
Calcium bicarb.	1,829.14	3,380.84	2,519.74
Barium bicarb.	16.67	25.65	25.00
Strontium bicarb.	Trace	Trace	Trace
Ferrous bicarb.	9.94	40.07	5.86
Magnes. bicarb.	753.89	2,244.88	1,186.57
Alumina	7.14	4.98	6.37
Silica	19.40	14.40	12.80
Total	7,284.00	15,808.30	10,130.48

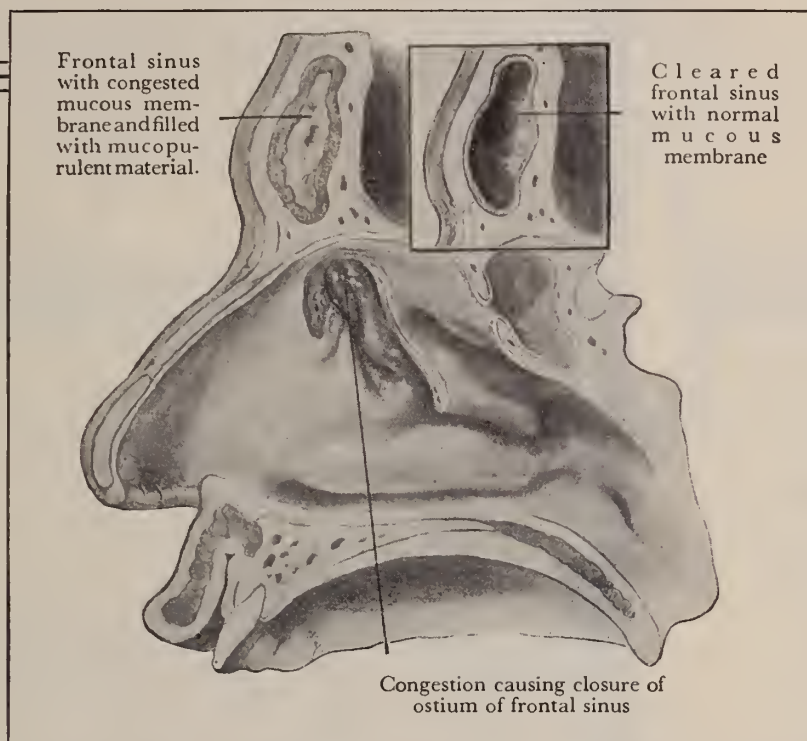
Look for the Seal of The State of New York on every bottle of the genuine waters of Saratoga Spa.



THE BOTTLED WATERS OF
SARATOGA
SPA

GEYSER • HATHORN • COESA

PATHOLOGY OF THE UPPER RESPIRATORY TRACT



CATARRHAL INFLAMMATION OF THE FRONTAL SINUS

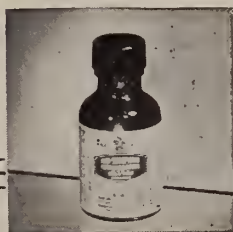
The above illustration demonstrates the route of infection to the frontal sinuses—demonstrates, too, the need for adequate drainage of the area. To shrink congested nasal mucous membranes quickly—to establish adequate drainage with more prolonged effect than ephedrine, may we recommend

NEO-SYNEPHRIN HYDROCHLORIDE

(laevo-alpha-hydroxy-beta-methyl-amino-3 hydroxy ethylbenzene hydrochloride)

DOSAGE FORMS:

- SOLUTION**—¼% in saline solution (½ oz. and 1 oz. bottles)
1% in saline solution (½ oz. and 1 oz. bottles)
¼% in Ringer's Solution with Aromatics (½ oz. and 1 oz. bottles)
- EMULSION**—¼% low surface tension (½ oz. and 1 oz. bottles)
- JELLY** —½% in collapsible tube with applicator



SOLUTION



EMULSION



JELLY

FREDERICK STEARNS & COMPANY, Detroit, Michigan

New York

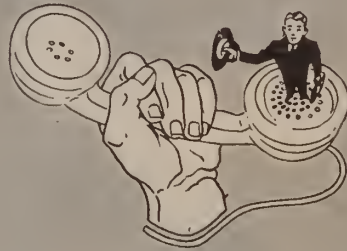
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965 Broad St.

W. C. MOORE, Mgr.

J. P. CORKILL

E. HAAS

He's G-E's direct representative who regularly makes the rounds of physicians and hospitals in your locality, and responds to their emergency calls for expert technical service or advice on the operation and maintenance of x-ray and other electro-medical devices.

He is neither an agent or distributor for G-E apparatus, but is a permanent employee on G. E.'s payroll, and works under the jurisdiction of a nearby G-E Branch.

What does this mean to users of G-E equipment? Just this: That a specially trained field organization, directly responsible to headquarters, is carrying out company policies established in the interest of customers, and rendering a caliber of maintenance service essential to the consistently satisfactory performance of electro-medical apparatus

Twenty years of direct G-E representation have conclusively proved that this plan operates to the distinct advantage of all concerned, and will fully justify every dollar that you, too, might invest in G-E equipment.

The G. E. men who are serving these mutual interests in your locality are listed herewith. We sincerely believe that you will find them a reliable source of helpful suggestions.

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F. J. MULLOWNEY

**GENERAL  ELECTRIC
X-RAY CORPORATION**



THE THIN MAN

The undernourished, underweight individual, whether man, woman or child, requires special dietetic attention. COCOMALT, three times daily in milk, when extra calories and additional food essentials are needed, is often recommended by the profession. As a between-meal feeding, it has also proven of value.

Recent studies¹ show that in groups of both children and aged the addition of COCOMALT to the diet in regular amounts resulted in substantial weight gains and improved blood picture. Further mentions are made by medical commentators² with inclusion of COCOMALT in successful diet lists for thin patients.

The vitamin-mineral character of this malted food drink supplies important nutrients in diets for all ages. COCOMALT also provides a drink whose taste appeal acts as an incentive to drink more milk.

Cocomalt

... for both normal and therapeutic diets ... contains calcium, phosphorus, iron ... Vitamins A, B₁, D ... Quick energy and body building nutrients.



C O C O M A L T
Enriched Food Drink for All Ages

R. B. DAVIS COMPANY • Hoboken, N. J.

¹ Arch. of Ped.—56:Nov. 1939
Medical Rec.—Aug. 21, 1940

² Medical Rec.—150:1:1939
Arch. of Ped.—57:488 (July) 1940

WHAT HAPPENS WHEN SMOKERS INHALE?

(and all smokers do—some of the time)

When smokers inhale, naturally exposure to irritation increases. In recognized laboratory test*, the irritant quality of the smoke of the four other leading brands averaged *more than three times that of the strikingly contrasted Philip Morris.*

Further—the irritant effect of such cigarettes was observed to last more than 5 times as long*.

The more smokers inhale, the more important for them to change to Philip Morris.

PHILIP MORRIS

PHILIP MORRIS & COMPANY, LTD., INC.,
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*Facts from: *Proc. Soc. Exp. Biol. & Med.*, 1934, 32,241
N. Y. State Jour. Med., Vol. 35, No. 11,590 *Arch.*
Otolaryngology, Mar. 1936, Vol. 23, No. 3,306

THESE NAMES, THESE YEARS...

HAVE HELPED MAKE MODERN MEDICAL HISTORY

1938 Butt, Snell, and Osterberg, also independently Warner, Brinkhous, and Smith, report effective use of vitamin K in abnormal bleeding of obstructive jaundice.

Smith, Ungnade, and Prichard; Bergel, Jacob, Todd, and Work; Karrer, Fritzsche, Ringier and Salomon — almost simultaneously announce the synthesis of vitamin E.

Parke, Davis & Company introduces Dilantin Sodium for the treatment of epilepsy.

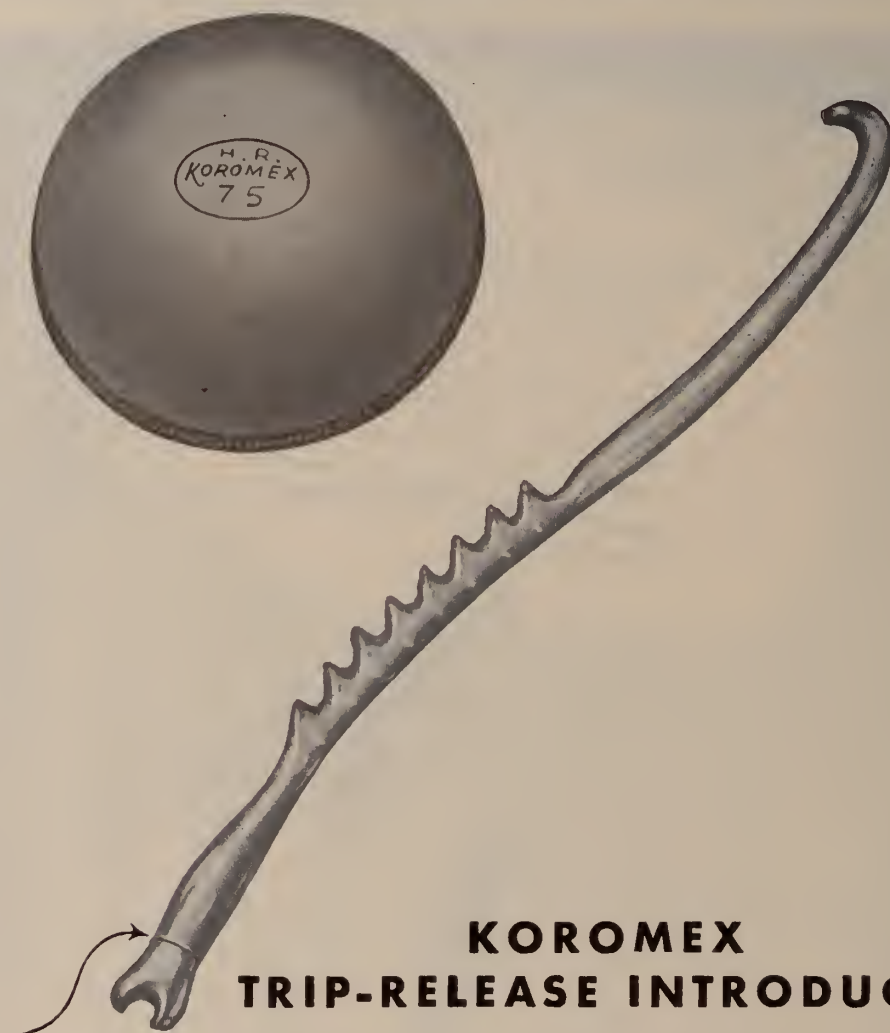
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PIONEERS IN RESEARCH
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TIP TURNS
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Faithfully Yours **FOR THESE MANY USES**

NUPERCAINE*

Topically administered, Nupercaine, "Ciba" has honestly earned a position of importance as a local anesthetic of prolonged, intense action in rhinology, urology, ophthalmology, dermatology and dentistry.

For Infiltration Anesthesia, non-narcotic Nupercaine (alpha-butyl-oxy-cinchoninic acid diethyl-ethylene-diamide-hydrochloride) is firmly entrenched as a dependable product.

For Spinal Anesthesia, Nupercaine has garnered a reputation second to none, with impressive papers in the field obtained during the past several months.

The relative low toxicity of Nupercaine when properly used, and its many other advantages, have been the subject of almost 2,000 articles in the professional press. . . Literature cheerfully furnished.

TABLETS • POWDER • SOLUTION • AMPULES



*Trade Mark Reg. U. S. Pat. Off. Word "Nupercaine" identifies the product as alpha-butyl-oxy-cinchoninic acid diethyl-ethylene-diamide hydrochloride of Ciba's manufacture.



CIBA PHARMACEUTICAL PRODUCTS, Inc., SUMMIT, N. J.



"It's so good, mother." All important to a child. But the doctor wants to know, "Is it good *nutritionally?*" . . . Kemp's Sun-Rayed Tomato Juice was originally made for infant feeding—with high retention of vitamins A, B₁, C. The same precautions have been continued in producing this *whole* tomato juice for all ages. Tomatoes are U. S. Government graded, individually trimmed and cored, and *all* the red-ripe solids converted into juice by Kemp's patented process No. 1746657. New York's largest seller. SUN-RAYED CO., Frankfort, Indiana.



NON-SEPARATING . . .

Never **THIN OR WATERY**



*"More Than
Two-Thirds of All Head-
aches Are Due to
Defective Eyes."*

Thus speaks a medical man after more than fifty years in the practice of medicine.

Knowing that wrong glasses at any age will aggravate the eye mistakes and cause more eye trouble, we Guild Opticians are endeavoring to enlist the aid of the Family Physicians in directing their patients to Eye Physicians.



Guild of Prescription Opticians of New Jersey, Inc.

**EYE PHYSICI-
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prescriptions for
glasses are
"Safe" when re-
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Carrel's immortal chicken-tissue serves research at Lederle Laboratories—

It was in 1912 that DR. ALEXIS CARREL put this bit of chick embryo heart into a nutrient and made it grow. Every 48 hours since then it has doubled. If it had been feasible to multiply the tissues to their greatest possible extent, today their mass would be bigger than the solar system. When DR. CARREL retired, the strain was brought to Lederle, where it lives on in the right environment. Here cultures from it serve as standards for studying the growth of certain viruses. And it is a useful tool for measuring antiseptic values. Indeed research has put immortality to work!

Tissue culture has become a productive art and the control of 65 virus diseases of man or beast is a proper task for research in the world's largest immunological establishment. Four buildings (out of 67) are devoted to viruses—the two largest are used entirely for research.

LEDERLE LABORATORIES, INC.

30 ROCKEFELLER PLAZA

NEW YORK, N. Y.





Q. I always use the syrup in which canned fruit comes. But has it any food value?

A. I am glad to learn you use it because it has excellent food values. It contains sugar and other carbohydrates as well as valuable food components, such as vitamins and minerals. ⁽¹⁾

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- ⁽¹⁾
1925. J. Home Econ. 17, 377.
1930. J. Home Econ. 25, 588.
1938. Commercial Fruit and Vegetable Products, Second Edition,
W. V. Cruess, McGraw-Hill, New York.
1940. J. Hygiene 40, 699.



The Seal of Acceptance denotes that the nutritional statements in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

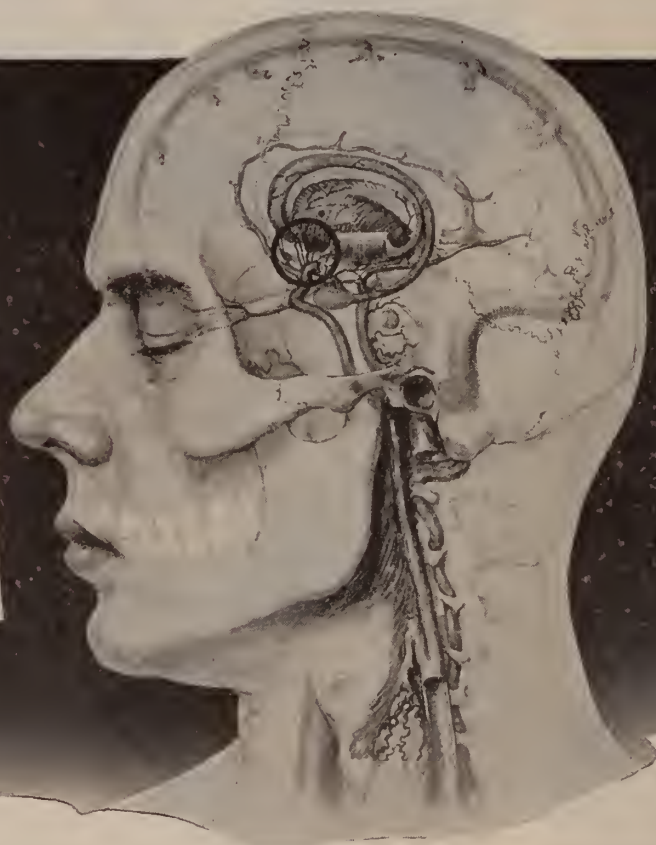
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Erythrol Tetranitrate Merck

FOR ARTERIAL SEDATION IN HIGH BLOOD PRESSURE

Action Begins in about 15 Minutes After Administration . . . Persists for 3 to 4 hours

Sagittal Section of the Head and Neck. Circle Indicates Lenticulostriate Artery, the One Most Commonly Involved in Cerebral Hemorrhage.



THE management of hypertension includes mild and long continued arterial sedation. For this important purpose, sustained vasodilatation may be obtained with ERYTHROL TETRANITRATE MERCK by careful adjustment of dosage in the individual case. It is also reported of value in angina pectoris and especially for the prophylaxis of anginal pain.

**ERYTHROL
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For Prolonged
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—A NEW VITAMIN-ENRICHED BLEND OF
TOMATO JUICE AND ACIDOPHILUS MILK

T.A. overcomes the distaste some patients have for the flavor of plain acidophilus milk.

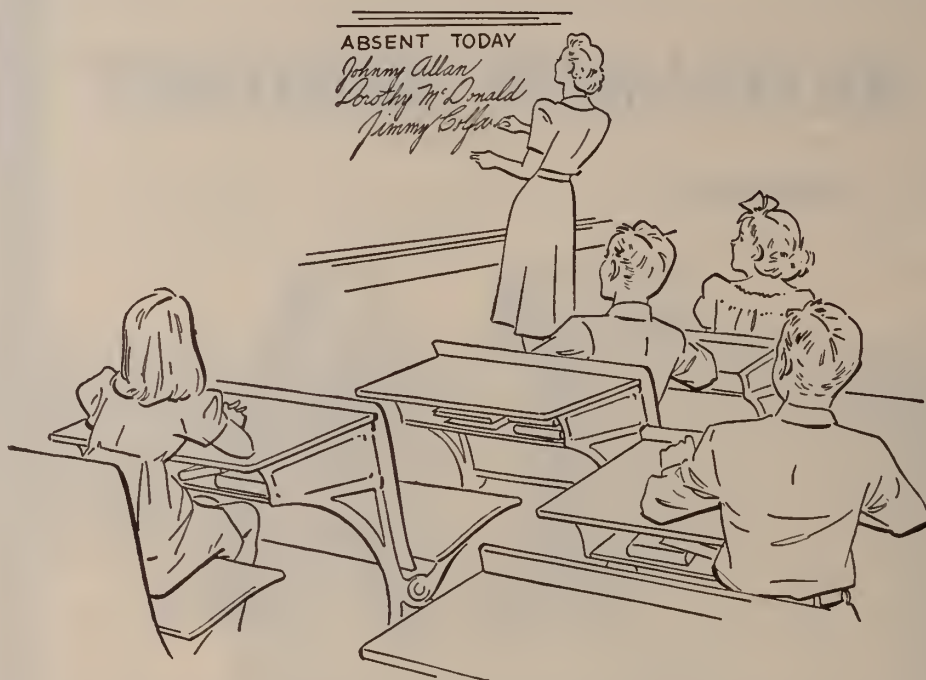
T.A. provides an ample supply of the beneficial acidophilus bacilli—more than 500,000,000 per c.c.

T.A. also provides, in a single pint, vitamins A, B₁, and D in amounts sufficient to meet the usual needs for health, regardless of any extra

vitamins obtained from balance of diet: A—4,000 U.S.P. units; B₁—333 U.S.P. units; D—400 U.S.P. units. Also a substantial amount of vitamin C.

T.A. is made fresh every day at the Walker-Gordon Laboratories; it is delivered by the Borden milkmen. For further information, write Walker-Gordon Laboratories, Plainsboro, New Jersey.

Home with a head cold



When you prescribe Racéphedrine Hydrochloride (Upjohn) for topical use in children, your small patients will find that it relieves nasal congestion

without unpleasant smarting or burning. The reason is that the vehicle used in making the 1% solution is isotonic, and therefore relatively nonirritating.

RACÉPHEDRINE HYDROCHLORIDE (UPJOHN)

is available as:

Solution Racéphedrine Hydrochloride (Upjohn) 1% in Modified Ringer's Solution, in one ounce dropper bottles for prescription purposes, and in pint bottles for office use

Capsules Racéphedrine Hydrochloride (Upjohn), $\frac{3}{8}$ grain, in bottles of 40 and 250 capsules

Powder Racéphedrine Hydrochloride (Upjohn), in $\frac{1}{4}$ ounce bottles



If the patient reclines on the side with the head at an angle of about 45°, a decongestant solution applied to the lateral aspect of each nostril will reach the orifices of the nasal sinuses of both sides.

Upjohn

KALAMAZOO, MICHIGAN



Fine Pharmaceuticals Since 1886



Physiologic Basis of **DIURETIC THERAPY**

When the glomerular and tubular functions of the kidneys become impaired, alterations in the mechanism of urinary secretion occur. Often there results

a retention of water with generalized edema. In such cases it is believed that Salyrgan-Theophylline lowers tubular reabsorption and thus permits the excretion of water and salt.

Salyrgan-Theophylline is extensively employed in the treatment of cardiac and cardiorenal edema as well as dropsy of nephrosis. It can usually be administered periodically without loss of potency.

Salyrgan-Theophylline is injected intravenously or intramuscularly.

**WINTHROP
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*Pharmaceuticals of merit
for the physician*

**NEW YORK, N. Y.
WINDSOR, ONT.**



HOW SUPPLIED: Salyrgan-Theophylline solution (containing 10% Salyrgan and 5% theophylline) is supplied in ampules of 1 cc., boxes of 5, 25 and 100; and in ampules of 2 cc., boxes of 10, 25 and 100.

SALYRGAN - THEOPHYLLINE

"Salyrgan," Trademark Reg. U. S. Pat. Off. & Canada

(Mercury salicylallylamide-o-acetate of sodium with theophylline)

Brand of MERSALYL
 with
Theophylline

“Bricks, travertine marble, and apparatus cannot solve problems or make discoveries but may be tremendously useful at the command of knowledge and skill.”

SECONAL

(Sodium Propyl-methyl-carbonyl Allyl
Barbiturate, Lilly)



‘Seconal’ fulfills the requirements for a hypnotic in the majority of medical and surgical patients. Action is prompt, the period of sleep is restful, aftereffects are negligible. ‘Seconal’ has definite uses in insomnia, nervousness, extreme fatigue with restlessness, and similar conditions where only a brief sedative effect may be required to allow onset of natural sleep.

Supplied in 3/4-grain and 1 1/2-grain pulvules in bottles of 40 and 500.

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THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

PUBLISHED MONTHLY SINCE SEPTEMBER, 1904

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DIRECTION OF THE
COMMITTEE ON PUBLICATION



HENRY C. BARKHORN, M.D., Chairman

HENRY A. DAVIDSON, M.D., Editor

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OCTOBER, 1941

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Single Copies, 30 Cents

THE LEGISLATOR AND THE DOCTOR

A few months ago, the New Jersey Legislature sent greetings to The Medical Society. Our profession, however, has yet to felicitate the Legislature. We doctors, accustomed to a highly individualized type of practice, are prone to think of a legislative body as a sort of impersonal backdrop to government. We forget that the Legislature is made up of individuals.

Who are these Senators and Assemblymen who enact the laws by which we practice? They are, after all, human beings, with all the sensitiveness and warmth of other human beings. And it seems reasonable to suppose (all whimsy to the contrary notwithstanding) that most of them must have some sort of superiority in terms of leadership, aptitude or intelligence, to have been elected at all. Seldom can a nonentity win public votes or attract the attention of a political leader.

The daily stint of the legislator is a heavy one. Almost a thousand bills a year must be read, analyzed, studied and voted upon. The pressure applied by dozens of organized groups and hundreds of clamoring individuals must be met. To withstand these pressures, to give serious attention to the bills, to evaluate public opinion—to do all this requires exceptional patience, integrity, intelligence and courage.

**FOURTH ANNUAL
FALL CLINICAL CONFERENCE
December 3, 1941
ELIZABETH, NEW JERSEY
HOST: UNION COUNTY MEDICAL SOCIETY**

The individual doctor and The Medical Society have a legitimate and extensive interest in their activities. About one bill in ten has some medical or public health implication. It is proper, therefore, that we give some thought to our relationships with our law-makers.

Our reaction towards legislation is determined by the way in which it affects public welfare. This, not our personal interest, measures our attitude. We can

repeat this, but we will not always be believed because it seems contrary to human nature. It is inevitable that some legislators will assume that we support bills which protect and condemn bills which impair our professional interests. After all, other organizations lobby in their own behalf and the public cannot see why a medical society should be different. We have endorsed some measures which divert patients from our own offices; we have supported bills which would reduce disease incidence and thus lower our own incomes. We can remind officials of this repeatedly but some of them will still cling to the notion that The Medical Society is just another self-seeking pressure group.

It would be better if the cause of public health could be consistently championed by lay groups—civic organizations, P.-T.A.'s, voters' clubs, welfare societies and other agencies which are interested in public health but which do not make their interests known to the Legislature.

One thing we can do: we can applaud a legislator whose voting record on health measures is good. We can keep ourselves informed about the Senators and Assemblymen who oppose baneful legislation and who fight for the protection of community health. And when we recognize

that a legislator has made a creditable record, we can tell the world that here is a public official who takes seriously his duty to promote public welfare. When a law-maker sponsors an unsound measure, we are quick to condemn him. When he favors desirable health legislation, we appreciate his action, but he usually receives no token of this, and he has no way of realizing that we show our recognition of his good work at the polls. An annual thank-you note from a County Medical Society or from individual physicians to the county's representatives at the State House, would be a deserved acknowledgement, a commendable courtesy and a way of encouraging continued health sensitivity on the part of our law-makers.

The recent health-legislation record of our Legislature has, on the whole, been a splendid one. Let The Medical Society here register its thanks to the Senators and Assemblymen who have enacted the legislation that has made it possible for the medical profession to make New Jersey a place of safe factories and farms, healthy schools and homes. They have erected bulwarks against quackery, set up a top-notch Health Department and kept our medical legislation in tune with the times. Their enactments have been, for us, a vote of confidence. Let this be, for them, a vote of thanks.

LITTLE WHITE LIES

The prime dilemma through all medical history has been whether to tell the truth to a fatally ill patient.

There are those who believe that no good ever comes out of deception; that it is more honest and more humane in the long run to tell a patient that he is the victim of an incurable or inevitably fatal disease. There are those who say that such a practice is not only cruel but inac-

curate, since tomorrow some new remedy may come into our ken which will remove a disorder from the classification of the hopeless to that of the treatable.

Patients themselves usually say: "Tell me the truth, Doctor, I'd rather know, and I can take it." It is doubtful, however, whether even the sturdiest wants to have a death warrant read to him.

This much seems incontrovertible: the

physician who discovers or diagnoses a hopeless ailment must transmit that information to some responsible member of the family. To tell the patient that he is doomed to an early death, however, seems pointless, for it is impossible to see any good that could come out of such a procedure except in a small group of cases in which rearrangement of a man's business affairs might make for financial security in his family. Even in these cases it would seem sufficient to tell the patient that he would be too sick to carry on his

business for a long time, and that he should adjust his affairs accordingly.

To transmit a verdict of inevitable death under any other circumstances, however, appears utterly without justification except perhaps the abstract one of rigid truthfulness, no matter what the cost. Since the emotional state of the patient is so large a factor and since the hopelessly sick patient has so few comforts, there would appear to be no justification for taking from the tiny reservoir still available, that one last blessing in Pandora's Box.

THE PUBLIC AND THE CLINICAL CONFERENCE

The value of the Clinical Conference, as a tool of graduate education, is too obvious to require reiteration here. We forget, however, that such a conference is also invaluable to public relations work. In any county in which it may be held the Clinical Conference is news—with a capital "N". For one day the host city becomes the medical center of New Jersey, and the newspapers of the community are swift to recognize the importance of such an event. Last year's Clinical Conference, for example, resulted in column after column of publicity, photographs, and reports in the papers of the Essex County area. Indeed, the amount of space devoted to it by one Newark newspaper alone exceeded 84 inches and would have been equivalent to a newspaper column 7 feet long. The Conference in Hudson County two years ago likewise aroused tremendous popular interest in the Jersey City area. Further, your Public Relations Committee stands ready to broadcast summaries of the papers to all the newspapers of the State.

The Clinical Conference breeds good will for the medical profession because it

highlights the strides that modern medicine is making in wiping out disease and improving health; because it calls public attention to the fact that this progress has been due to the alertness and intelligence of the medical profession; and because it indicates that New Jersey is awake to the newest developments in modern medicine. The Conference reminds the community that our own State, though unblessed with a medical school, is in a position to deliver to the public every detail of up-to-the-minute medical practice.

Finally, the Conference reminds the public that physicians have something more to do than to talk about medical economics. It underscores the fact that when all the shouting and tumult about state medicine, medical preparedness or health insurance dies down, there still remains the one solid function of the medical profession: improving the health and physical well-being of the citizens of the United States.

PUBLIC RELATIONS COMMITTEE,
Medical Society of New Jersey.

THE NEW JERSEY FORMULARY

By this time every member of The Medical Society of New Jersey should have received a copy of the fourth edition of the New Jersey Formulary.

The fact that this booklet has survived to its fourth edition proves that there was a demand and a need for it. It is a pocket-sized, ready reference book for the physician. The list of formulas is not large but is sufficiently comprehensive to meet the more common requirements of general practice.

A number of improvements will be noted in this fourth edition. Some new prescriptions have been added and several old ones deleted. A larger and more legible type has been used.

A physician who will take the time to give this little book some study will find it a great aid to his prescription writing. It will help him to combat the tendency to prescribe certain proprietary prepara-

tions. Writing a prescription for a proprietary product is of course easier and quicker but with a little more thought it can be done in a more dignified and ethical way. A well-written prescription designed to meet the patient's individual needs makes a much better impression than an order for a ready-made proprietary. It should be remembered that the proprietary *prescribed* by the physician today is often the patent medicine *advertised* to the public tomorrow.

Keep your New Jersey Formulary handy. Refer to it often, for by so doing, the art of prescription writing will be revived and the cost of medication to patients materially lowered.

CHESTER I. ULMER, M.D.,
Chairman,

Committee on Pharmaceutical
Problems.

WHO WILL CALL THE "SIGNALS"?

The football season is at hand. The team that consistently wins is the one in which each player is primarily a unit whose efforts are well integrated into the plays of the team. He must be individually well prepared and trained, but it is the teamwork which wins the game, and it is the player who calls the signals who runs the team.

Teamwork is co-ordinated effort under centralized direction and control, but operated strictly within the rules and regulations established by the authorities. Who will make the best "quarterback"—government or private interests? This question is more widely debated today than ever, but government today holds

the authority, and the funds of the people so definitely (and almost exclusively) that the "signals" will probably come from that source—at least in the emergency, and possibly even for many years to come.

A good football player or a good physician will play his *best* on any good team, and will be in demand at all times. The lesson for us as physicians is to establish and maintain our reputation—play the game fairly and hard—and help the *team* to win the game under all circumstances.

LEROY A. WILKES, M.D.,
Executive Officer,
The Medical Society of
New Jersey.

ORIGINAL ARTICLES

DECLINE IN PREVALENCE OF SYPHILIS
AS SHOWN BY ROUTINE TESTS IN A HOSPITAL

By A. J. CASSELMAN, M.D., Dr. P.H., and ANABEL CADWALLADER, Trenton, N. J.

This is a continuation of a study published in 1935* of results of routine blood testing for syphilis in the West Jersey Hospital, Camden,—a general hospital. The figures suggest a downward trend in the prevalence of syphilis in Camden during the past fifteen years.

In 1926 one of us was in charge of the syphilis clinic at the West Jersey Hospital, Camden, and developed a definite procedure of having blood tests for syphilis done on all hospital patients, private as well as ward patients. This plan has been a hospital routine ever since. Each day the laboratory technician secures the list of patients admitted during the preceding twenty-four hours, and checks to make sure that blood specimens are collected. Such cases as tonsillectomies and minor accident cases frequently are missed because of the short duration of their stay, and in private cases the physician in charge may have previously examined the patient for syphilis; babies delivered in the large maternity department of course are not included; but with these exceptions a consistently faithful effort has been made to test all hospital patients.

The technic of the laboratory test used has not been changed materially since routine serologic testing for syphilis was begun in the hospital, and we believe that results have been unusually consistent. Overnight cold fixation and the Nieman and Gager cholesterolized alcoholic extract of ether extracted beef heart are the essential features which make the tests extremely sensitive. The local laboratory has been checked with other laboratories frequently.

METHOD OF STUDY

For purposes of this study it was decided that a sufficiently accurate analysis of results

could be made from 500 cases in alternating years since routine testing for syphilis was established. Accordingly the figures in Table I represent the first 500 hospital patients (sixteen years of age or over) tested in 1927, 1929, 1931, 1933, 1935, 1937, 1939, and 1941, a total of 4000 patients. There is a downward trend in the percentage of positives over the fifteen-year period (Table I).

TABLE I.—RESULTS OF ROUTINE SEROLOGIC TESTS FOR SYPHILIS OF ADULT PATIENTS AT THE WEST JERSEY HOSPITAL, CAMDEN, AS INDICATED BY A STUDY OF 4000 CASE HISTORIES

Year	No of Cases Studied	Positive Tests	
		No.	Per Cent
1927	500	43	8.6
1929	500	23	4.6
1931	500	32	6.4
1933	500	24	4.8
1935	500	22	4.4
1937	500	14	2.8
1939	500	16	3.2
1941	500	14	2.8
	4000	188	4.7

These figures except for 1939 and 1941 were secured by an examination of individual treatment records, a time-consuming job. Beginning in 1938, a separate record book has been kept with the names of hospital patients tested for syphilis and the results of their tests. This has made it possible to compile quickly the figures for the first 500 patients and also the figures for the entire year, as has been done for 1938 and 1940:

ALL HOSPITAL PATIENTS (IN-PATIENTS) TESTED

	Number	Per Cent Positive
1938	2263	3.5
1940	2537	2.0

By the study of the treatment records of individual patients the figures through 1939 have been broken down by race and for ward and obstretic cases (Tables II, III, IV).

*Routine Wassermann Tests in a Hospital. A. J. Casselman, M.D., Dr. P.H., and Anabel Cadwallader. Journal of The Medical Society of New Jersey. July, 1935.

TABLE II.—CLASSIFICATION BY RACE OF 3500 OF THE PATIENTS TESTED FOR SYPHILIS IN HOSPITAL ROUTINE

Year	White			Negro			Race Unknown	
	Total No.	Positive Tests No.	Per cent	Total No.	Positive Tests No.	Per Cent	No.	No. Positive
1927	427	25	5.9	46	18	39.1	27	0
1929	456	12	2.6	32	10	31.3	12	1
1931	461	24	5.3	31	7	22.6	8	1
1933	440	14	3.2	52	10	19.2	8	0
1935	479	17	3.5	21	5	23.8		
1937	465	8	1.7	35	6	14.1		
1939	462	10	2.2	38	6	15.8		
	3190	110	3.45	255	62	24.31	55	2

Of the 174 persons in this study through 1939 who had positive tests (see Table I), 36 per cent were Negroes, although only seven per cent of the total number of persons tested were Negroes. Table II compares the number of tests and results among both races.

Twenty-four per cent of the Negroes were positive, as against 3.5 per cent of the white patients. Both races show a similar marked decrease in percentage of positives in the thirteen-year period.

In the previously published report of results of tests at West Jersey Hospital for the years 1927-34, the cases were classified as private and ward. Of the private room patients, the mean percentage of positive tests was 1.3 as compared with 8.2 per cent of the general ward patients, who are in general from the less favored social groups. As there was such a markedly higher percentage of positives among the low-income group, this group has been further analyzed. Table III shows the breakdown of the general ward patients according to race. Positive results are six times more frequent proportionately among the Negro than among the white general ward patients.

These findings point to the need for increased efforts to control the spread of syphilis among Negroes. Other studies have indicated a similar racial differential. A recent article¹ calls attention to the fact that of 226 positive premarital tests made in the New Jersey State laboratory, 114 were of Negroes and 112 were of white persons, although Negroes comprised only about five per cent of the total number of persons tested for marriage licenses.

OBSTETRIC CASES BELOW AVERAGE OF INFECTIONS

Because of the new prenatal law, which makes it the duty of physicians to have serologic tests for syphilis done on pregnant women under their care, statistics regarding prevalence of syphilis among pregnant women are of special interest. Therefore, the data from obstetric cases were compiled separately. The percentage of positive results is consistently lower in this group than in the total; the mean percentage of positive cases is 3.3 as compared with five per cent of the total group. Table IV shows the number of obstetric cases (private and ward in the proportion of about one private to two ward cases) among the 3500 histories studied, and the results of the tests by years.

TABLE IV.—RESULTS OF ROUTINE TESTS FOR SYPHILIS OF 1082 OBSTETRIC PATIENTS, PRIVATE AND WARD

Year	No. of Cases in Study	Positive Tests	
		No.	Per Cent
1927	173	13	7.5
1929	105	1	1.0
1931	125	7	5.6
1933	150	3	2.0
1935	154	6	3.8
1937	181	3	1.7
1939	194	3	1.6
	1082	36	3.3

Table V is a classification of the obstetric cases by race. About eight per cent of the obstetric records studied were of Negroes, as compared with seven per cent of the total 3500 cases.

1. Nine Months' Experience with the New Jersey Premarital Medical Examination Law. John Hall. Journal of Social Hygiene, May, 1939.

TABLE III.—CLASSIFICATION BY RACE OF GENERAL WARD CASES IN THIS STUDY

Year	White			Negro			Total		
	Total No.	Positive Tests No.	Per Cent	Total No.	Positive Tests No.	Per Cent	No.	Positive Tests No.	Per Cent
1927	200	12	6.0	26	9	34.6	226	21	9.3
1929	233	9	3.9	28	10	35.7	261	19	7.3
1931	258	17	6.6	19	5	26.3	277	22	8.0
1933	217	13	6.0	27	8	29.6	244	21	8.5
1935	201	12	6.0	7	1	14.3	208	13	6.3
1937	132	2	1.5	13	2	15.4	145	4	2.8
1939	157	6	3.8	12	5	41.7	169	11	6.5
	1417	71	5.0	132	40	30.3	1549	111	7.2

ONE-THIRD OF POSITIVE CASES UNDER AGE OF THIRTY

The 174 patients who had positive tests are grouped according to age in Table VI. Doubtless some of these infections were acquired years before and had never been diagnosed. Frequently the statement “denies venereal infection” appeared on the patient’s history.

TABLE VI.—CLASSIFICATION BY AGE OF 174 PATIENTS WITH POSITIVE SEROLOGIC TESTS

Age	Number of Patients	Per Cent of Total
16-19	15	8.6
20-29	42	24.1
30-39	47	27.0
40-49	26	15.0
50-59	25	14.4
60-69	15	8.6
70-	4	2.3
	174	100.0

CLINICS HAVE BEEN MAINTAINED FOR MANY YEARS

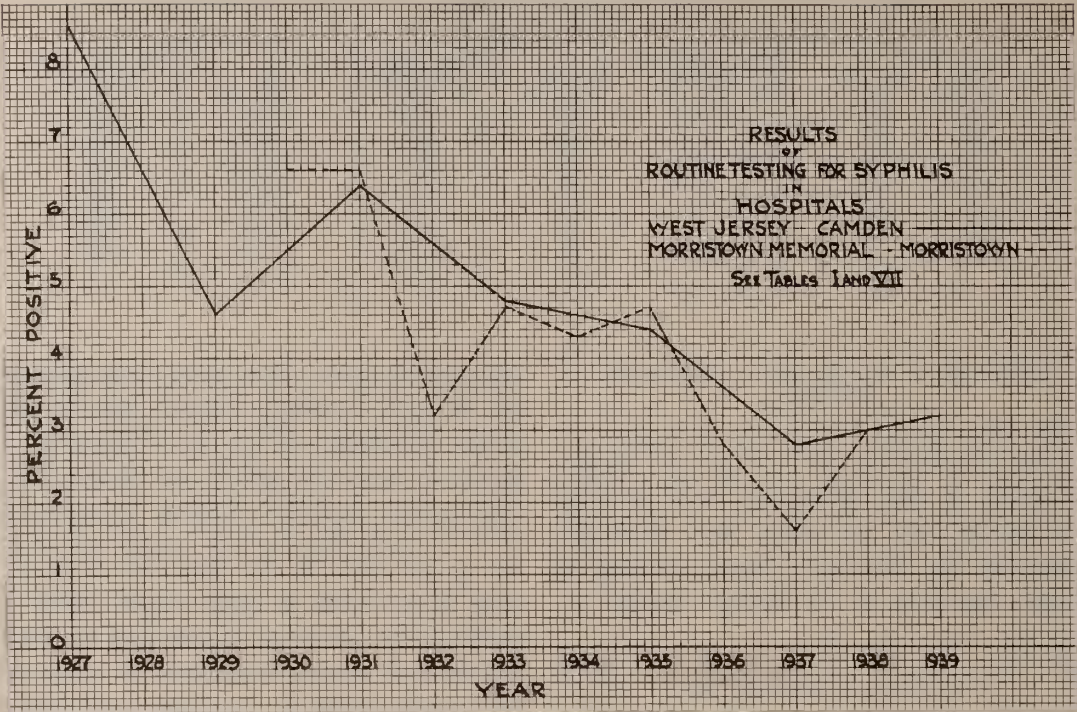
There have been no unusual efforts to control the spread of syphilis in Camden to suggest that the decrease in number of cases found in this study of a cross-section of the population might be peculiar to that city. For the

past twenty years clinics have been maintained by the two hospitals (Cooper and the West Jersey Hospital) where free treatment was given to those who applied, the number of patients under treatment ranging from one hundred up to the five hundred enrolled at present. No special effort to find cases was undertaken until 1937, when a public health nurse was assigned by the State Department of Health to the local health department to carry on a case-finding program. A trained social hygienist residing in the community has stimulated some community interest in sex education. These activities, however, are common to most other New Jersey cities; in fact, many cities have waged more aggressive campaigns.

We are encouraged to believe that the operation of clinics throughout the State over the past twenty years; the increasing use by physicians of improved facilities and newer methods of diagnosis and treatment; and the educational and epidemiologic activities of some of the local health departments and the State Department of Health may have been productive of a significant reduction in the number of infected persons throughout the State.

TABLE V.—CLASSIFICATION BY RACE OF 1082 OBSTETRIC PATIENTS TESTED FOR SYPHILIS

Year	White			Negro			Race Unknown	
	Total No.	Positive Tests No.	Per cent	Total No.	Positive Tests No.	Per Cent	No.	No. Positive
1927	135	7	4.4	12	6	50.0	26	0
1929	95	0	0	3	0	0	7	1
1931	113	5	4.4	8	1	12.5	4	1
1933	126	1	0.8	23	2	8.7	1	0
1935	144	2	1.4	10	4	40.0		
1937	167	1	0.6	14	2	14.3		
1939	175	2	1.1	19	1	5.3		
	955	18	1.9	89	16	18.0	38	2



Fall in incidence of positive reactions for syphilis.

NUMBER OF POSITIVE TESTS DECLINE IN
MORRISTOWN ALSO

Support for this assumption comes from Morristown, a residential community in the northern part of the State, as contrasted with Camden, an industrial city in the southern part. Results of routine testing at the Morristown Memorial Hospital since 1930 show a downward trend similar to the West Jersey Hospital, Camden. The method of record-keeping at the Morristown Memorial Hospital made it possible to secure for comparison the

number of positive tests on all persons (private and ward) admitted to the hospital since 1930, which are given in Table VII. A study of the individual patient histories was not undertaken; hence, no classification of patients is possible.

ROUTINE TESTING HAS EDUCATIONAL VALUE

The practice of testing for syphilis routinely in hospitals has resulted in a diagnosis of syphilis in many cases that would have been missed otherwise. Today the value of this plan as a

TABLE VII.—RESULTS OF SEROLOGIC TESTS FOR SYPHILIS ON ALL IN-PATIENTS EXCEPT CHILDREN AT THE MORRISTOWN MEMORIAL HOSPITAL, MORRISTOWN, 1930-39

Year	Ward Patients—			Private Patients—			Total		
	No. Tested	Positive Tests No.	Per Cent	No. Tested	Positive Tests No.	Per Cent	No. Tested	Positive Tests No.	Per Cent
1930 . . .	540	40	7.4	155	6	3.8	695	46	6.6
1931 . . .	624	42	6.7	139	9	6.4	763	51	6.6
1932 . . .	512	18	3.5	293	8	2.7	805	26	3.2
1933 . . .	546	31	5.6	304	9	2.9	850	40	4.7
1934 . . .	631	37	5.9	294	3	1.0	925	40	4.3
1935 . . .	618	39	6.3	339	6	1.8	957	45	4.7
1936 . . .	644	26	4.0	274	0	0	918	26	2.8
1937 . . .	531	11	2.0	293	2	0.7	824	13	1.6
1938 . . .	760	32	4.2	426	4	0.9	1186	36	3.0
1939 . . .	772	30	3.9	483	4	0.8	1255	34	2.7
1940 . . .	582	26	4.5	492	3	0.6	1074	29	2.7
	6760	332	4.9	3492	54	1.5	10252	386	3.8

diagnostic aid is generally recognized and most hospitals are testing routinely at least in the wards.

We cannot measure the educational value to interns, nurses, patients, and public of the procedure as carried on at the West Jersey Hospital, Camden, over a fifteen-year period. It must have been an important factor in stimulating greater use in private practice of the blood test for syphilis.

SUMMARY

This is a continuation of a study published in 1935 of results of routine blood testing for syphilis at the West Jersey Hospital, Camden. Records of 4000 unselected adult patients from 1927 to 1941 inclusive showed that 188, or

4.7 per cent, had positive tests. Of the 188 who had positive tests, 36 per cent were Negroes although Negroes comprised only seven per cent of the total number of patients studied.

A steady decrease in the percentage of positive tests from 1927 to the present is shown in both races, suggesting that there is a downward trend in the prevalence of syphilis in Camden.

A similar downward trend was noted at the Morristown Memorial Hospital, Morristown. Tests on all in-patients from 1930-1940 show a mean of 3.8 per cent positives and a drop in percentage of positives from 1930 to 1940 similar to that at West Jersey Hospital.

1 West State Street

TO MINIMIZE POST-TONSILLECTOMY DISCOMFORT

The extreme pain and discomfort following surgical removal of the tonsils may be reduced to a minimum by means of a flap of mucous membrane from the tonsil which is used to cover the wound made by the operation, Robert H. Fowler, M.D., reports in *The Journal of the American Medical Association*.

"Today the surgeon in almost every instance can assure the patient that the tonsils will be successfully removed—the tonsil, the whole tonsil and nothing but the tonsil—without injury to the other structures of the throat," Dr. Fowler says, "yet four decades ago such assurance was the exception rather than the rule. Up to the turn of the century tonsillotomy was practiced; in the second decade of this century too much was removed; automatic instruments came into vogue which stripped away from the throat a thin sheet of muscle; in the third and fourth decades standards of removal of the tonsils have been improved until a 'muscle free dissection' is the common aim of all. . . .

"For fifty years we have seen the tonsillar fossa neglected after all traditional operations and the whole raw surface of the wound after enucleation left exposed to every accident of trauma from food in the throat and to its full quota of infection.

"It takes but a minute to cut a flap at the time of the first incision of the mucous membrane; it takes less than a minute when the tonsil has been removed to anchor this flap with a catgut slipknot to the fascia at the center of the wound in such a way as to help nature in the healing.

"The new plan of repair designed to minimize convalescence by partially covering the exposed portion . . . with a protective mucous membrane at the time of operation obviates the most severe pain and discomfort later. The patient eats breakfast the next morning. The time for the wound to cover over is lessened by half, and the amount of scarring is almost nil. No longer does tonsillectomy involve a large open wound set to catch food and become infected and so entail great discomfort and soreness for ten days. Rather it has become a question of how successful the surgeon has been in covering the most vulnerable and sensitive part of the wound and quickening the healing forces of nature to repair the throat with a minimum of discomfort, distortion and disturbance of function. . . .

"The number of operations in which plastic flaps have been used has run into the thousands. There have been no bad results."

DIFFERENTIAL DIAGNOSIS OF ACUTE LOWER ABDOMINAL LESIONS IN THE FEMALE *

By WILLIAM J. CARRINGTON, M.D., Atlantic City, N. J.

This is a perennial topic. In the last five years, 855 articles on but one phase of the subject, appendicitis, have been published. Yet, in any large hospital almost every day sees a consultation over some perplexing lesion of the lower abdomen or pelvis. The Atlantic City Hospital records for the past five years tell an interesting story.

Sudden intolerable abdominal pain accompanied by unmistakable rigidity is a surgical green light regardless of exact diagnosis. Wangenstein's decompression and parenteral fluids give extra time for greater accuracy, but even with these, delays may spell disaster.

It is embarrassing to operate for appendicitis and find the mesenteric adenitis of what turns

FEMALE PATIENTS WITH LOWER ABDOMINAL AND PELVIC EMERGENCIES

January 1, 1936—December 31, 1940

	Final Diagnoses	Tentative Diagnoses Correct	Accuracy
1. Acute Appendicitis. Including purulent appendicitis, abscess, gangrene, perforation, and peritonitis	760	664	87.3 %
2. Acute Adnexitis. Including acute salpingitis, pyosalpinx, tubovarian abscess, and pelvic peritonitis G. C. in origin	485	362	74.6 %
3. Acute Lesions of the Urinary Tract. Including cystitis, interstitial cystitis, pyelitis, stone, pyelonephritis, pyonephrosis, ptosis of the kidney, and stricture of the ureter	81	78	92 %
4. Endometriosis	56	6	10.7 %
5. Hernia, strangulated or incarcerated. Including inguinal, femoral, and intraabdominal	46	41	93.1 %
6. Ruptured Cysts. Including graafian follicle, corpus luteum, dermoid, pseudomucinous, and papillary cysts	40	22	55 %
7. Ruptured Ectopic. Including ruptured tubal pregnancy and tubal abortion ..	35	21	57.1 %
8. Torsion of Myomata and Ovarian Cysts	12	5	41.7 %
9. Puerperal Pelvic Cellulitis. Including post abortive and early or late puerperal sepsis	10	8	80 %
10. Mesenteric Adenitis. Due to measles, scarlet fever, and "glandular" fever	9	0	0 %
11. Tuberculous Peritonitis	7	1	14.2 %
12. Mittelschmerz	6	0	0 %
13. Meckel's Diverticulitis	5	0	0 %
14. Torsion of the Omentum	3	0	0 %
15. Perforated Typhoid Ulcer	1	0	0 %

The art of diagnosis is based on the recognition of signs and symptoms. It is often necessary to wait for them to develop before an exact diagnosis can be made. In abdominal catastrophes, mistakes are pardonable. The unpardonable sin is to wait until error is impossible. That would mean the sacrifice of human life on the altar of statistical perfection.

out to be measles. But once in a while pain, McBurney tenderness, rigidity, fever and leucocytosis antedate the rash. When the surgeon is called to see such a case he knows that appendicitis in childhood demands early operation because nature makes no effort to wall off the infection. He operates in good faith. Give him sympathy. He will blush for himself.

It is embarrassing to miss the diagnosis in ruptured ectopic. Fifty-seven per cent of ac-

* Read at Atlantic City, N. J., May 20, 1941, before the Annual Meeting of The Medical Society of New Jersey.

curacy is not too good. In typical cases the ambulance driver can take one look and do better than that. But all are not typical. Some years ago I had a series of ectopics, with regular menstruation and moderate hemorrhage which promptly ceased spontaneously. I missed so many that I wrote on the preoperative chart the exact opposite of what I really thought and was 100 per cent correct.

CASE HISTORY

The impression is inescapable that many mistakes could have been avoided if *clues in the histories* had been followed. Signposts which pointed the way were disregarded.

If the onset occurs at the time of menstruation, the reproductive organs may or may not be the site of the lesion. Appendicitis, acute or chronic, occurs more frequently when there is pelvic congestion. There is delayed or missed menstruation in 85 per cent of ectopics. Fever and chills following childbirth or abortion suggest pelvic cellulitis. Dysmenorrhea, which begins late in menstrual life in the third decade, which becomes more distressing each month, which is seen in women in the upper walks of life who have used contraceptives, is usually due to endometriosis. Had we known that, we could not have missed 50 out of 56 cases.

The *sequence of events* is important. If there is sudden pain in the periumbilical region shifting to the right lower quadrant, nausea and vomiting, tenderness, rigidity, fever, and leukocytosis in that order, the diagnosis could hardly be plainer if flashed in neon lights. The trouble is that many things break up the sequence, such as pelvic appendix or failure of the cecum to rotate. However, nausea and vomiting are the clues to follow. The first symptom of appendicitis is pain, *always pain*, never anything else. If some other symptom is first, the appendix is blameless. The site and severity of the pain is constant, but pain comes first. A history of "cold in the bladder", leucorrhea, or Bartholinitis directs attention to the adnexa. If gastro-intestinal symptoms are absent, if the pain is deep in the pelvis and constant rather than paroxysmal, the diagnosis of adnexitis is fairly certain.

Women are constipated bipeds. In appendicitis and strangulated hernia the constipation is more absolute, but 15 per cent of appendicitis cases have diarrhea and most of these die. If food, fluid, or physic be given a patient with appendicitis, the pain becomes intolerable and recovery difficult and doubtful. Appendicitis is bad enough, but its axis partners—food, fluid, and physic—are worse. They bring peristalsis, perforation, and peritonitis.

Many authors state that females are less susceptible to appendicitis than males, in the ratio of 2 to 3 or even 2 to 5. Atlantic City Hospital records would seem to confirm this. There are fewer cases in women's surgery than in men's surgery; but if those treated in the gynecological department be added, there is little difference in the two sexes.

A generation ago surgeons were taught that the ovarian artery had an appendicular branch which furnished extra blood and hence relative immunity to the female. Today every modern text book states that the blood supply of the appendix is the same in the two sexes.

CLINICAL FINDINGS

1. *Posture.* If the patient lies on either side there is no peritonitis. If she lies with her right thigh flexed, she may have phlebitis, but she is more apt to have appendicitis. This position does not relieve the pain of adnexitis, or of urinary tract lesions. It is, therefore, of real diagnostic value. In perforation of a viscus the patient lies immobile, stiff as a mummy. In ruptured ectopic, she is restless, tossing from side to side, begging for water. In streptococcic cellulitis, she is bright, flushed, and talkative. Her euphoria may confuse the unwary.

2. *Temperature, pulse, and respirations* are not very helpful. In appendicitis and adnexitis there is moderate elevation. In cellulitis the temperature is pump-handle. In pyelitis, pyelonephritis, and pyonephrosis there may be wide fluctuation. When an ectopic ruptures the temperature drops. Later there is fever due to absorption of fibrin ferment. A lower abdominal emergency without fever or leukocytosis is apt to be the sudden twist of the pedicle of a solid or cystic tumor. If the torsion is neg-

lected, particularly if the cyst be a dermoid, peritonitis quickly follows with fever and leucocytosis.

The pulse varies with the amount of shock and hemorrhage. It is more rapid in cellulitis. In perforation there are pallid face, staring eyes, and sweated brow, but the pulse is surprisingly tranquil.

Respirations are accelerated in all abdominal catastrophes, but air hunger is the distress signal of internal bleeding.

3. The *localization of tenderness* is of the utmost importance. The patient will point out the area of greatest tenderness. In appendicitis it finally settles near McBurney's point. In salpingitis it is lower and is apt to be on both sides. Morris's points have not been very helpful. In urinary tract lesions the tenderness is over the bladder or flanks. In pelvic cellulitis there is little or no tenderness unless peritonitis develops.

In pregnancy, the ovaries, tubes, and appendix are lifted up. While pregnancy does not appear to increase the liability of primary attacks of appendicitis, recurrences are all too common. Increased blood supply, constipation, and elevation of the cecum with pull on old adhesions combine to relight previous trouble. Perforation and abscess are much more dangerous in pregnant women. Abortion or premature labor is the rule and when the uterus empties itself it pulls away and disseminates the infection.

4. *Cutaneous hyperesthesia*, tested by pinching the skin, may reveal hypersensitiveness over the appendix. The sensory nerves of the skin in that area come from the same segment of the cord supplying the appendix with its sympathetic nerve fibers. One should not place too much reliance on this sign because it requires a subjective response.

5. *Muscle spasm* is of prime importance, but can be elicited only by gentle manipulation. The intensity of rigidity depends upon the proximity of the appendix to the parietal peritoneum. In salpingitis, rigidity is less and bilateral because heavy inflamed tubes prolapse in the cul de sac. In ruptured ectopic, rigidity is generalized. In pelvic cellulitis and

torsion there is no rigidity until peritonitis sets in.

Muscle spasm is not marked in typhoid perforation because this accident occurs in the third week. By this time Zender's degeneration, in fifth-column sort of way, has rendered the rectus muscle incapable of resistance.

Rebound tenderness indicates peritoneal involvement, but it excites undue pain and apprehension and may actually spread infection.

6. *Abdominal Mass*.—A readily palpable, rounded mass low in an acute abdomen suggests a solid or cystic tumor with a twisted pedicle. In early appendicitis the omentum wraps itself around the appendix to form a tender indefinite mass. An appendiceal abscess, which takes some days to form, may be felt in the lower right quadrant, in the flank, or in the pelvis. I once opened, in my office, what appeared to be a large fluctuating femoral gland abscess which pointed below Poupart's ligament. Imagine my surprise when a gangrenous appendix floated out in the pus.

7. *Abdominal auscultation* is too often neglected. In obstruction, peristalsis is tumultuous and long gurgling, guttural rolls are characteristic. In peritonitis there is stony and ominous silence, broken now and then by a reverberating drip like water falling in the silence of a resonant cave. In hemorrhage there is said to be crepitus.

8. *Pelvic Examination*.—A distinguished author suggests that "if the history and abdominal findings are inconclusive, a careful yet gentle pelvic examination assumes great importance". In reviewing our mistakes, the most vivid impression gained was that *more errors were committed by omitting the pelvic examination than by omitting all other diagnostic procedures combined*. May we, therefore, urge pelvic examination through the vagina or through the rectum not only when the history and abdominal findings appear to be inconclusive, but in all cases?

An intact hymen rules out salpingitis almost certainly, but a palpable Bartholin's gland, purulent Skenitis or urethral discharge is strong circumstantial evidence, and cervicitis in a nullipara is more than gossip.

Tenderness of the adnexa is best demonstrated by a maneuver not described in text books. The examining finger pushes the cervix to the right. The uterus acts as a lever and puts the right adnexa on stretch. Tenderness elicited by this simple maneuver earmarks the diagnosis.

Induration of acute salpingitis may be demonstrable only when the patient is relaxed. With the patient and the operating room prepared for appendectomy, if the relaxation of the anesthesia permits a correct diagnosis, it is sound judgment to postpone operation until the tube "cools off".

Pelvic examination is important in suspected ectopic. The uterus is enlarged, the cervix is soft, and there is slight bleeding. The pregnant tube "rides high" and forward, whereas pus tubes are heavy and fall back into the depths of the cul de sac.

Large pelvic abscesses of recent origin are almost certainly appendiceal. These collections of pus cannot be palpated through the abdomen, but only through the vagina or rectum. They should be drained through the cul de sac, because they are closed off above by coils of intestine.

A small pelvic abscess may be appendiceal where the appendix hangs over the brim of the pelvis. But this abscess is high whereas a tubovarian abscess is low in the cul de sac. Moreover, tubal masses are sausage-shaped and bilateral. Unilateral pyosalpinx is due to pyogenic cocci and not to gonococci.

Appendicitis secondary to tubovarian disease is not alarming, because the inflammation involves the peritoneal coat and not the lumen of the appendix. It is safe to allow the case to subside even though it be certain that the appendix is involved.

If pelvic examination reveals a retroflexed uterus with "frozen" adnexa and a "shotty feel" along the uterine ligaments, the diagnosis of endometriosis is probable. If speculum examination reveals small chocolate cysts or their little stellate scars in the vault of the vagina, endometriosis is certain.

Pelvic mass may be due to a solid or cystic tumor. Torsion of such a tumor is one of the

causes of acute lower abdomen. Cysts that twist are of medium size. Sometimes the twisted pedicle can be palpated. If such a patient develops early peritonitis, one should suspect a dermoid, because its contents are particularly irritating.

Crepitus means clots of blood and hence ruptured ectopic or ruptured cysts with internal bleeding.

LABORATORY AID

The help that urinalysis has to offer is so well known that comment is unnecessary. A single specimen may show neither blood nor pus if the ureter is temporarily blocked in pyelitis, pyelonephritis, or pyonephrosis. On the other hand, blood and pus may appear in the urine where there is no real urinary tract infection, but where there is extension from a retrocecal appendix or a tubovarian abscess.

The leucocyte picture depends upon the nature of the infection, the tissue involved, and the factors that promote absorption. Other things being equal, staphylococci, gonococci, and *B. coli* excite leucocytosis less than streptococci. The tissue invaded influences the count. Thus tuberculosis and typhoid which invade the lymphoid tissue show a low count, whereas infection of the peritoneum causes enormous polymorphonuclear increase. Moreover, a small amount of pus under pressure, as an abscess confined to the appendix, will produce a higher count than a large abscess that is draining.

In bleeding ectopic, leucocytes continue to rise but drop quickly when hemorrhage ceases.

With physical signs and leucocytosis of 15,000 the appendix may be expected to be inflamed. When the count approaches 20,000 there is usually pus. If the count is less than 12,000 there may be obstructive appendicitis with colicky pains and rupture. This sequence of events causes 90 per cent of appendiceal deaths. In this group an increasing shift to the left is an urgent indication for early operation. Finally, it should be remembered that leucocytosis occurs in uremia, acidosis, intestinal obstruction, coronary thrombosis and even in alcoholic cases.

In ruptured ectopic the first blood count may

show an actual increase in red cells due to the blood concentration of shock. However, evidences of anemia soon appear. Because cells regenerate more rapidly than hemoglobin, ghost cells are seen and the color index is low.

Hemoglobin is not an accurate indicator of internal hemorrhage. It does not reach its highest level until 48 to 72 hours of bleeding. That is why a high hemoglobin does not rule out ruptured ectopic. Falling blood pressure is more valuable than falling hemoglobin in the diagnosis of hidden hemorrhage. According to Farrar, a complete blood count every two hours will indicate when bleeding starts and stops, and this observation has been confirmed time over and again.

The sedimentation rate varies with extent and severity of the infection. It tells more than leucocytosis about the end stages of disease. When the rate is rapid in P. I. D., operation is risky and followed by stormy convalescence.

The rate in appendicitis is slower than in P.I.D. or in pelvic cellulitis. In differentiating between ectopic and pelvic inflammation a slow rate points toward ectopic. However, sedimentation is valueless as a diagnostic aid after the third month of pregnancy, because it is always rapid from the third month until two weeks after delivery even in the absence of inflammation.

Blood cultures, the Friedman test, and the complement fixation test for gonorrhea do not help solve acute diagnostic problems. Special diagnostic procedures are rarely useful. These are cystoscopy, x-ray, the Rubin test, and the Bastedo procedures. Colpotomy is useful in slow bleeding ectopics. We have no desire to possess a peritoneoscope. We have seen it used elsewhere. It is brutal and futile. The shock of inflating the peritoneal cavity with air and the danger of perforating the gut are too great and the keyhole view is unsatisfactory even for the most ardent Peeping Tom.

905 Pacific Avenue

COD-LIVER OIL THERAPY OF BURNS AND WOUNDS

Cod liver oil is sterile and bactericidal. It may be applied to the naked brain, the cornea, the exposed intestines, and all other tissues without irradiation or fear of infection. As a wound dressing it possesses a unique stimulating effect on granulation and epithelization. This results in rapid regeneration of tissue defects. The stimulating effect is probably chiefly due to its vitamin A and D content. The oil exerts also a beneficial generalized systemic effect, accelerates liquefaction of necrotic tissues, reduces the toxicity of pus, forms a protective non-irritating layer over the wound, requires infrequent dressings, is painless, and minimizes cicatrization.

Cod liver oil therapy produces more rapid wound healing than other methods. It is so effective in cleaning up infected wounds and

stimulating healing that it replaces Dakin's solution. It also offers an effective method of treatment applicable to the more severe major burns of all types, and superior in certain respects to other methods of local burn therapy, especially in third-degree burns.

Cod liver oil ointment is recommended as a superlative method of local wound therapy applicable to both clean and infected wounds of all types and in the treatment of both new and old burns of major severity. The first cure of chronic undermining burrowing ulcer with cod liver oil is reported as well as the first successful application of the oil to the naked intestines in two cases of complete rupture of an infected abdominal wound, with cure.—P. C. Hardin, South. Surgeon, 10:301. (Clinical Abstracts, 1941.)

THE PSYCHOSOMATIC CONCEPT IN MODERN MEDICINE

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One has but to listen to the radio to note the multitudinous advertisements of preparations for the relief of acid stomach, headaches, constipation and many other discomforting conditions. There must be a tremendous demand for such preparations.

When they go to their doctors, too many of these sufferers are simply told that these conditions are purely nervous and are given by prescription practically the same drugs. Physicians infrequently think of their patients as total individuals. They think of the body—the “soma”. But how about the mind—the psyche? Still more important, what about the combination: psychosomatics?

GENESIS OF PSYCHOSOMATICS

The genesis of psychosomatics is to be traced back to the time eons of years ago when psyche (mind) became a unity with the original protoplasm, the primordial cell, as it lay in some protected pool lighted and warmed by the sun's rays.

Psyche, purposeful energy has carried through this original cell from its incipency through all the stages of evolution to its supreme development *homo sapiens*.

It is far beyond the space allotted to this article to consider the source of the emotions in the cerebrum, the hypothalamus and the autonomic system. It must therefore be briefly stated that it is through these channels that the psyche produces normal functioning over the portions of the body (soma) which it controls or dysfunction when it is disturbed. This disturbance may be on a very superficial and totally conscious level or the disturbance (conflict) may be located down deep in the unconscious. The former case may frequently be successfully handled by the simpler forms of psychotherapy but the latter necessarily can only be successfully treated by the trained psychiatrist.

CONSCIOUS WORRY

The psyche may be disturbed on the conscious level; that is to say, the sufferer may “feel worried”. It may be a specific worry; or it may be a general anxiety, the cause of which is not known to the patient. The former are the simpler cases and may often be satisfactorily handled by a physician, who by confidential interviews with his patient may show him how to meet the situation face to face, get it “off his chest”, so to speak, teach him to carry on. Thus a satisfactory adjustment to reality is brought about and the patient relieved of his discomforts.

UNCONSCIOUS ANXIETY

However, there is another class of case in which the conflict is more or less deeply seated in the unconscious. Here we find the anxiety neuroses. The patient does not understand the cause of his worry, and it can be discovered only by deep psychologic investigation. In these cases with many and frequent interviews, through free association and the interpretation of dreams, the psychiatrist can bring to the surface, the conscious level, the hidden conflict which may date back to infancy or early childhood.

It must be remembered that well-trained psychiatrists are few and that much harm may be done by the untrained. The situation may well be compared to the danger of a surgeon's knife in the hands of a tyro.

THE CLINICIAN'S ROLE

As Alfred Stengel says: “The physician who underrates the psychic factor in disease, even in the grossly organic diseases, loses an opportunity for effective treatment that would distinguish the successful from the unsuccessful practitioner.” This from an internist, not a psychiatrist! Dr. Henry R. Christian of Boston has always stressed the investigation of disease as part of a living subject rather than as

a controlled experiment. The implication is that the patient has a mind as well as a body. These eminent clinicians with many others in the profession realize that man is something more than matter.

DIGESTIVE DISORDERS

Digestive disorders are extremely common, hence the tremendous demand for alkalinizers over drug counters, and the oceans of radio ballyhoo on the subject. Of course, alkalinizers do not affect the cause, yet this is all that is practicable in the vast majority of instances owing to the great vicissitudes of daily life.

A very common disturbance of the digestive tract is the condition frequently spoken of as "colitis" but which would be better termed the "nervous colon", the "irritable colon" or the "spastic colon".

Here is a case in point. A middle aged spinster, a business woman, and the sole support of her aged parents, had suffered for a year from frequent abdominal cramps, many daily defecations of mucus, loss of appetite and strength all leading to great fear of losing her job and its attendant mental depression.

She went to physicians, dietitians, osteopaths, by whom she was told to rest and diet. She received large quantities of drugs, all to no avail. Finally she was referred to a psychiatrist who delved deeply into her psyche with the gratifying result that after several weeks of interviews her symptoms became less severe and finally disappeared entirely. Her gastro-intestinal status became normal and with the exception of infrequent and slight returns of her symptoms has been in excellent health.

HEART DISTURBANCES

Here is a case of conversion hysteria in which the heart did the "play acting". It came to my attention many years ago long before such a diagnosis could be made but looking back upon it now with more modern knowledge, it appears typical.

The patient was the wife of a physician. Their love for each other was ideal and intense. In early life the wife overheard the family doctor tell her parents that she had heart disease. Early in married life she developed severe

attacks of precordial distress causing great anxiety to the husband who, unable to connect the symptoms with the valvular lesion she was known to have, labelled the attacks "false angina". She became a chronic invalid, spending most of her time in bed or on a couch. This lasted for years. When the husband died, the shock to his widow was terrific as she had been very dependent upon his attention and care which he devotedly gave. From the time of his death there were no further "anginal" attacks. Psychiatrists say that these cases represent a selfpunishment or atonement for a sense of guilt existing on the unconscious level and therefore of course unknown to the sufferer. This sense of guilt probably dates back to some forgotten happening in early childhood. They tell us that some terribly distressing experience even on the conscious level (in this case the death of the beloved husband) may satisfy demand for further punishment and with it the cessation of the symptoms. This woman had to suffer for years but today might have been relieved by modern psychiatric methods.

SKIN LESIONS

The earliest amoeba had a skin, or at least it had a containing membrane. The skin and its preëxisting representatives go back a million or even a billion years, and long antedate the gastro-intestinal tract. It must have had a good many experiences as an individual organ.

A few years ago the writer attended an illustrated lecture, at which the demonstrator threw upon the screen tremendously enlarged, actual photographs of living amoebae. To demonstrate the containing membrane of this primordial cell and its reactions to stimulation, an individual cell was shown while being irritated by a needle. Of course these needles were not even of the finest steel, but were pieces of glass tubing drawn out to points invisible to the naked eye. By means of clamps attached to the stage of the microscope these points were caused to approach and irritate the cell membrane and to demonstrate what the cell would do under such conditions. The experiment demonstrated the relative toughness of the protective membrane as compared with the

contained protoplasm. The lecturer was able to penetrate this membrane and inject the protoplasm with a dye. Even this earliest matter reacted to irritation.

Throughout its entire history the skin has been a more or less sensitive tissue for it is simply a mass of cells and intercellular tissue lavishly supplied with vascular and nervous elements. This nervous supply responds to emotional stimuli. Thus we see blanching of the skin under the emotion of fear; or blushing under the emotion of embarrassment. These reactions are relatively simple, but many more complex skin conditions are due to psychic causes. The following abbreviated case history has been selected.

A happily married man in the middle thirties with a much-loved three-year-old daughter, inherited with three older brothers a retail business in a large city. He had been graduated from college where he had specialized in accounting. He took up the position of office manager in the family business. He shortly developed a troublesome skin affection characterized by large areas of redness and pruritus. Physiotherapy and surface applications failed to relieve him. No allergic state could be found. The itching became intolerable and the induced scratching led to extensive excoriations. He was then referred to a psychiatric resort. After a comparatively short series of psychotherapeutic interviews and an outdoor life he returned home entirely free of his skin disease and in vastly improved health. Resuming his office work, it was but a short time before his symptoms returned. He reentered the institution and as it was believed that his relapse was due to friction with his brothers in the office he was advised to sell his share in the business. He did so, and except for a normal anxiety as to a future suitable occupation, has since lived happily with his family and free of his skin disease. Psychotherapy had succeeded where simple "somatic" forms of treatment had failed.

It must not be taken for granted that all cases of skin disease based upon a psychosomatic cause are so easily cured. Many are due to disturbances in the deep unconscious to be cured only by regular psychoanalysis.

WAR NEUROSES

Some of the "war neuroses" form excellent examples of what an "escape mechanism" may accomplish. During the first World War, a psychiatrist described a case he had been called to see in a reconstruction hospital. The patient was an army nurse who had been under a great strain, mental and physical, at the front. The sights she witnessed there must, at times, have seemed unbearable. In the course of her duties she had sustained some slight injury to a knee. The joint became progressively painful and sensitive with later muscular contractions. Under the influence of narcotics with the joint protected from the weight of the bedclothes by a "cradle" she was brought to this country for hospitalization. Customary treatments having failed, it occurred to the surgeon that the condition might be of psychic origin. The psychiatrist confirmed this and within an hour all symptoms had disappeared. Before he left the hospital the patient was able, with aid, to take a few steps about the ward. In this case we see a war neurosis undoubtedly based upon an unconscious desire to escape from an increasingly painful mental situation.

About this time I was attending a play in a New York theatre. In the audience was a party of soldiers returned from France for rehabilitation. Between the acts I engaged one of them in conversation. It seemed that he was convalescing in one of the city hospitals. After telling him that I was a physician I asked him what his trouble was. "Epileptic fits," he explained. He had never had them before joining the army. Further questioning brought to light that his treatment consisted of sedatives, rest and diversion. But this boy was not getting what he most needed: psychotherapy. Here was another example of an escape mechanism in the form of occasional attacks of unconsciousness mislabelled "epilepsy".

DRAMATIC CURES

It is not an infrequent occurrence to read in the daily papers of some individual who has been bedridden for years with apparent loss of power of the lower extremities, yet who at the alarm of fire was able to get out of bed and with a little assistance reach a place of safety.

I spent several months on a cattle ranch in the Far West. In making arrangements for the visit, it was requested that I bring along my obstetric outfit as the wife of the ranch owner was pregnant. I made an examination, having been told that she had not menstruated for several weeks, that her breasts were enlarged and that she had morning vomiting in which her sympathetic and oversensitive husband had joined. While he waited in an adjoining room I made the examination and to my great astonishment and surprise found that the uterus was of normal size and shape. She was *not* pregnant. The diagnosis was "phantom pregnancy" (pseudocyesis). I told the husband the result of my findings, asking him to break the news to his wife. Naturally they were dumbfounded, but accepted my diagnosis without hesitation. Needless to say, the symptoms disappeared almost immediately. Here was a woman inordinately desirous of having a child. Her psyche actually developed the symptoms for her.

CONCLUSION

In conclusion I would like to refer to the excellent description of the possible effects of a disturbed autonomic nervous system in a recent article by Dr. Walter C. Alvarez. "An

unstable autonomic nervous system may play disconcerting tricks on the heart, blood vessels, digestive tract, kidneys and skin. There will be attacks when the patient will suffer with one or more symptoms like dizziness, faintness, trembling, jitteriness, chilliness, flashes of heat, flushing of the skin, sweating, waves of goose-flesh, palpitations, rapid and irregular heart beat, air hunger, quivering in the abdomen, intestinal cramping, diarrhoea, urticaria, bloating, frequent urination, perhaps a closing of the nasal passages and fears of impending disaster." An imposing array of symptoms but I regret that among them he has not included one which is very often psychosomatic in development, namely: constipation.

It is a satisfaction to know that these relationships between psyche and soma are becoming better known to the profession at large with the result of affording them a much broader insight into many of their clinical cases.

It has been the writer's objective to describe how the psyche influences body function and to give a few illustrative instances. The mind and body are *one*. Had it not been for "psyche", the tiny mass of original protoplasm might have remained as such in its warm and sunny pool.

146 E. 49th Street

CURRENT MEDICAL LITERATURE

The "Index Medicus", the guide to prior medical literature, is now supplemented by a "Current List of Medical Literature" issued through the Army Medical Library. This is a weekly index of current medical articles classed

under 44 functional headings. The subscription rate is \$5.00 a year, for the 52 weekly issues. Inquiries should be directed to the Friends of the Army Medical Library, Washington, D. C.

THE GENERAL PRACTITIONER AND THE ELECTROCARDIOGRAM

By JOHN H. ROWLAND, M.D., New Brunswick, N. J.

When the average general practitioner looks at an electrocardiogram or even at an electrocardiogram report, his face expresses a struggle between an attempt to look intelligent and all too evident confusion and bewilderment. This is hardly surprising. Most textbooks on electrocardiography are written so that only the specialist can really understand them. Under these circumstances it seems worthwhile to present the subject understandably for the general practitioner.

The electrocardiogram is a curve traced upon graph paper which records the electrical action of the heart as detected by the electrocardiograph. The vertical scale, between horizontal lines one millimeter apart, measures the voltage of the heart action. One millimeter of vertical height of the curve corresponds to 0.1 millivolt (when the electrocardiogram is properly standardized). The horizontal scale, between vertical lines one millimeter apart, measures the duration of the various segments. One millimeter of horizontal distance of the curve corresponds to a time of .04 seconds.

THE LEADS

Usually an electrocardiogram shows four curves, each the result of a different recording. The upper curve is obtained by using Lead I, for which the wires are fastened to the arms of the subject. The second curve is obtained by using Lead II, for which the wires are fastened to the right arm and the left leg. The third electrocardiogram curve is obtained by using Lead III, for which the wires are fastened to the left arm and the left leg. The lower curve is obtained by using Lead IV-F, for which the wires are fastened to the left leg and the other electrode is placed on the chest over the apex of the heart. The four results can be compared with one another, so that reliable interpretation can be made. Sometimes other leads are used.

THE P WAVE

The curve of every electrocardiogram representing a complete cycle of a heart beat has five waves. There are also three segments, each of which corresponds to a different stage of heart action.

The first, or P wave of the electrocardiogram, represents the spread of the electrical impulse over the auricles which is followed by the contraction of the auricles. In the normal heart, the curve of the P wave is an upright deflection, rounded, blunt, sometimes notched or scalloped, from one to three millimeters high. It is normally not over 0.1 seconds in duration as measured at the base line from the beginning of the up-stroke to the end of the down-stroke.

The first segment of the electrocardiogram, called the PR interval, represents systole and diastole of the auricles and the time required for the excitation wave to travel from the SA node through the auricular musculature to the AV node, through the bundle of His, and down to the upper reaches of the right and left bundle branches. The PR interval is measured horizontally only, from the beginning of the P wave to the beginning of the R wave, or, when a Q wave is present, to the beginning of the Q wave. What the R wave and the Q wave are will be made clear presently. In a normal heart the PR interval should not exceed 0.20 seconds in duration.

THE QRS COMPLEX

The second segment of the electrocardiogram, composed of the second, third and fourth waves, is called the QRS complex and represents the spread of the electrical impulse over the ventricle which is followed by ventricular systole. It starts at the end of the PR interval. The QRS complex may begin with a slight initial downward projection called the Q wave, or with a sharp spike-like upward projection

called the R wave. The Q wave, if present, is immediately followed by the R wave, which in any event returns to the base line. In its return, the curve may project below the base line. Such a downward projection is called the S wave. In normal heart action, the R wave should not exceed 30 millimeters or less than 5 millimeters in height, nor should the QRS complex exceed 0.1 seconds in duration.

THE RST SEGMENT

The third segment of the electrocardiogram, called the RST segment, is that part of the curve between the QRS complex and the T wave. In the normal heart, it will not extend more than one millimeter above or below the base line.

THE T WAVE

The fifth and last curve of the electrocardiogram (omitting from consideration the U wave) is the T wave, representing the relaxation of the heart and the decline of the state of electrical excitation in the ventricular muscle. In the normal heart, the curve of the T wave is blunt, rounded, upright, varying from one to five millimeters in height. It is normally not over .25 seconds in duration.

P WAVE VARIATIONS

The curves of the electrocardiogram as I have described them are obtained in the normal heart. An electrocardiogram which shows a variation beyond the limits described may be assumed to represent a heart in some way abnormal.

Variations beyond normal limits in the P wave include the following: a height greater than three millimeters, a duration of more than 0.1 seconds, an abnormal rhythm in the curve, or an inversion of the P wave itself. These abnormalities may be caused by the factors which produce auricular enlargement; for example, mitral stenosis, tricuspid stenosis, congenital heart disease, acute left ventricular failure, etc. Abnormal shapes of the P wave may indicate changes due to abnormal rhythm as in ectopic auricular rhythm or nodal rhythm. Sometimes the P waves cannot be observed or counted. This occurs in auricular fibrillation.

PR INTERVAL VARIATIONS

Variations from normal in the PR interval involve a duration longer than 0.20 seconds or shorter than 0.10 seconds. A prolongation of the PR interval may indicate a defect in the A-V conduction system. Such a defect is ordinarily produced by rheumatic fever, diphtheria, other acute infectious diseases, toxic doses of digitalis or quinidin, syphilis, or coronary artery disease. A shortening of the PR interval may indicate ectopic auricular tachycardia or ectopic nodal rhythm.

QRS COMPLEX VARIATIONS

Variations from normal in the QRS complexes include a prominent, rather than a slight, Q wave; notching and slurring in the curve of the R wave; excessive height of the R wave; a duration of the QRS complex in excess of 0.10 seconds. These variations in the QRS complex are characteristic of cardiac damage. Prolongation of the time interval of the QRS complexes is produced by intraventricular or bundle branch block. It is sometimes caused by quinidin, rarely by digitalis, and is sometimes seen in toxic uremia. The condition is more often associated with coronary artery disease, syphilis, mitral stenosis and patent intraventricular septum. It may be the sequel of acute infections like diphtheria and rheumatic fever.

Hypertrophy of either ventricle may be identified when the electrocardiograms from the three leads are mounted above one another in order. When a deep S wave forms the largest portion of the QRS complex in Lead I, and when at the same time the R wave forms the largest portion in Lead III, so that the complexes may be said to point towards each other, we have "right axis deviation". This indicates hypertrophy of the right ventricle. When the R wave is the largest portion in Lead I and a deep S wave is the largest portion in Lead III, so that the complexes may be said to point away from each other, then there is present "left axis deviation". This indicates hypertrophy of the left ventricle. Examination of the QRS complex will not identify cases of equal enlargement of both ventricles.

RST SEGMENT VARIATIONS

Variations from normal in the RST segment may appear as excessive extension of the curve above or below the base line. An excessive extension above the base line usually indicates acute myocardial changes such as occur in acute myocardial infarction and in pericarditis. Excess extension below the base line usually indicates chronic myocardial disease, coronary artery disease, myocardial fibrosis, old, healed myocardial infarction, toxic doses of digitalis or quinidin or the presence of hypertrophy of various chambers of the heart. Other causes for abnormal curves in the RST segment are acute infections, such as rheumatic fever, pneumonia, and typhoid fever.

T WAVE VARIATIONS

Variations from normal in the T wave include flattening or inversion, and enlargement. Flattening or inversion of the T wave may indicate toxic doses of digitalis, quinidin, nicotine, or insulin; alkalosis or acidosis; acute heart disease, including acute rheumatic fever, diphtheria, toxic goiter, trichinosis (when the heart is involved), myxedema, anesthesia, beriberi, or anginal syndrome; or any form of infection or intoxication. When the flattening or inversion of the T wave is permanent, there is indicated some form of chronic heart disease such as arteriosclerosis, syphilis, or rheumatic fever. An inverted T wave in Lead III occurs normally in patients with hypersthenic habitus. Inversion of the T wave in children may be normal. An enlargement of the T wave is sometimes associated with hyperthyroidism.

NORMAL LIMITS

In a general way the foregoing describes the significance of variations from normal. However, the reading of the electrocardiogram is far from simple. We are not quite certain as to what the limits of the normal curve are. The reason is that not enough electrocardiograms have as yet been taken of normal persons. The limits of normal could be ascertained if the insurance companies were to require electrocardiograms for all applicants.

"CARDIAC DAMAGE"

In the interpretation which accompanies an electrocardiogram report, the term "cardiac damage" is often used. It means "myocardial damage" and indicates ventricular myocardial involvement. Such a condition is indicated in the electrocardiogram by a related series of variations from normal. These, in my judgment, naming the most significant variations first, are as follows: the presence of a significant Q wave, excessive duration of the QRS complex, variations from normal in the T wave, variations from normal in the RST segment, notching and slurring of the QRS complex, and abnormally low voltage of the QRS complex.

DIAGNOSTIC VALUE

The electrocardiogram is of great value in the diagnosis of cardiac conditions within certain limits. In some cases its evidence conclusively demonstrates the existence of a specific cardiac condition. It can be relied on for diagnosis of recent coronary occlusion, of overdigitalization, and of bundle branch block. In certain cases when diagnosis may seem uncertain, a progressive series of electrocardiograms will reveal recent coronary occlusion, which could not otherwise be diagnosed. Such a progressive series is taken daily in indeterminate cases. A comparison of the electrocardiograms in a series will sometimes indicate progressive changes specifically associated with recent coronary occlusion. Sometimes a series will reveal changes non-specific in diagnosis; such as, evidence of low voltage, bundle branch block, extrasystoles, paroxysmal tachycardia, and fibrillation. In such cases, there is a strong suspicion of recent coronary occlusion, but accurate diagnosis requires the consideration also of clinical findings. Similar use of progressive series of electrocardiograms is efficient in determining more accurately the progress or recession of rheumatic carditis.

A warning to the general practitioner who does surgery should be added here. When an acute abdominal condition requiring surgical intervention exists, an electrocardiogram may show minor changes similar to those just de-

scribed for coronary occlusion. To diagnose coronary occlusion in such cases is an error.

The well-trained general practitioner might have considerable difficulty in distinguishing between a sinus arrhythmia complicated by extrasystole, and a slow auricular fibrillation. Sinus arrhythmia has usually no clinical significance; fibrillation has a relatively serious prognosis. But though the practitioner may have difficulty in distinguishing, diagnosis by the electrocardiogram is definite and sure.

Another difficult clinical problem is distinguishing between extrasystoles arising from multiple foci and those arising from a single focus. The former are more serious, but they cannot be readily distinguished without the electrocardiogram. Similarly, differentiation of auricular fibrillation on the one hand from partial A-V block with drop beats on the other is difficult without the electrocardiogram. Yet such differentiation is important from the standpoint of treatment, for the patient with auricular fibrillation is greatly benefited by digitalis, whereas to treat with digitalis a patient with uncomplicated partial A-V block may cause the development of complete block.

PSYCHOLOGIC VALUE

In addition to the value of the electrocardiogram for diagnosis, it possesses a psychologic value. When a patient has a classical syndrome of coronary occlusion, a general practitioner is generally competent to diagnose the condition without the electrocardiogram. However, in atypical coronary occlusion, some patients are so insistent that their own diagnosis is correct, that the physician sometimes assumes the presence of "indigestion". If, whenever the symptoms suggest this, electrocardiograms were to be taken, the result would be a diagnosis which the patient would respect. It is desirable to take an electrocardiogram in such cases since the patient may apparently recover and believe that there is nothing wrong with him at the very time that he is actually suffering from atypical coronary occlusion. Furthermore, the electrocardiogram, by convincing him that something is seriously wrong, would make him amenable to the advice of his physician. It is difficult to convince some patients without such

evidence. Thus, the successful business man who has always been enterprising and energetic, accustomed to dictate to those about him, is often scornful of a serious diagnosis and refuses to take the time required for rest and treatment. However, when diagnosis has been confirmed by the electrocardiogram, he is likely to be responsive. Besides, such confirmation gives the attending physician a great sense of assurance.

PRE-SURGICAL USE

In spite of the extensive information given by the electrocardiogram, it does not indicate decompensation or diminished cardiac reserve. When considering whether to operate, the practitioner must depend upon the history and physical examination, and upon his own judgment in these cases. However, an electrocardiogram, supplementing a thorough history and physical examination, may give vital information affecting the whole conduct of the operation. For example, it will inform him of the presence of heart conditions that might increase the surgical hazard; as enlargement of the cardiac chambers which occurs in syphilitic heart disease with aortic insufficiency; aortic stenosis; complete heart block and sometimes angina pectoris. Patients with these disabilities are liable to sudden death, and information disclosing them is therefore of great value.

PRACTICAL SUGGESTIONS

Whenever possible, the general practitioner will get the most satisfactory results if he refers patients for electrocardiograms to a physician associated with a cardiac clinic. Not everyone who has an electrocardiograph is able to interpret the electrocardiogram accurately. Often too much is read into the electrocardiogram because criteria for interpretation are absent. In order to make the most intelligent report upon a patient, the cardiologist should not only make and interpret the electrocardiogram but take the history himself, and do his own physical examination. Then he can suggest in his report such further methods of diagnosis as are revealed by a complete and thorough study. It is desirable that an electrocardiogram report be made in this complete

way. Often, however, the physician rendering an electrocardiogram report to a general practitioner assumes that the latter is qualified to take a detailed cardiovascular history and to do a thorough cardiovascular physical examination. Such an assumption is usually justified, but, unfortunately, it sometimes is not. Therefore the cardiologist should consider it his responsibility not only to render a conservative report of the findings on the electrocardiogram, but also to send a supplementary report to assist the general practitioner in the diagnosis, prognosis, and treatment. If this supplementary report is not rendered, the general practitioner unacquainted with the electrocardiogram may fail to interpret the report properly. He may, for example, become confused by negative findings in the electrocardiogram report and interpret these as indicating the absence of disease, whereas such interpretation may be incorrect.

The electrocardiogram has a very definite and important place in the diagnosis of cardiac

conditions. However, some authors suggest that dependence upon the electrocardiogram should not be stressed. These writers assert, what is true within certain limits, that the physician skilled in electrocardiography who has carefully studied the associated clinical manifestations of a disordered heart seldom needs to resort to the electrocardiogram in diagnosis. Such a statement should not be misconstrued by the general practitioner as meaning that the electrocardiogram is of little significance. On the contrary, it is of considerable value when evaluated in connection with a careful history, with a thorough physical examination, and with the other adjuncts necessary to an exhaustive study. Certainly, a cardiologist in Boston, no matter how competent in diagnosis, would not consider sending a report to a cardiologist in Philadelphia without having taken an electrocardiogram. It can be said with positive assurance that the electrocardiogram has not only an important but an indispensable part in a thorough cardiac study.

159 New Street

IMPROVING TOLERANCE TO THEOBROMIN

The use of xanthines in the treatment of edema has decreased greatly since the introduction of mercurial diuretics. Theobromin and theophyllin sodium acetate have been shown to be efficient xanthines in the treatment of angina pectoris. All xanthines, however, cause nausea and heartburn when given in large doses. These untoward gastric effects may be minimized by encasing the medication in "enteric coating", thus permitting its prolonged use in amounts adequate to keep certain patients free from edema. By this means, the necessity of intravenous administration of diuretics may be obviated or decreased, and the frequency

and severity of attacks of angina pectoris may be diminished. When the drugs have been given continuously for a long time, no untoward effects have been observed except for occasional slight gastric discomfort. The optimum dosage for most patients appears to be 0.5 gm. of enteric-coated theobromin sodium acetate, or 0.2 gm. of enteric-coated theophyllin sodium acetate, given four times daily, before meals and before retiring. Adequate dosage is necessary; in angina pectoris it is especially important to administer a dose of the medication before retiring.—J. E. Riseman and H. Linenthal, *New Eng. Journ. Med.* (Clinical Abstracts—1941).

EPIDEMIC INFLUENZA

By FREDERICK HNAT, M.D., Elizabeth, N. J.

Read before the Clinical Society of the Elizabeth General Hospital, Feb. 18, 1941.

The basic philosophy of ancient medicine was that supernatural forces caused disease. This type of thinking persisted until about 2300 years ago when Hippocrates supplied a philosophy that was to relieve the Gods of their responsibility for the prevention and treatment of disease and place that responsibility where it belonged: squarely upon the shoulders of man.

Let it be remembered that the period of the rise of modern scientific medicine covers only some 75 years. These years included such a discovery as the bacterial cause of infection, one of the greatest triumphs in man's search for truth. Yet with all our modern scientific methods, it is a remarkable fact that we have been, up to the present, in ignorance—like primitive man in a sense—of the most important questions of epidemic influenza, one of the most terrible of diseases. For instance, we are not certain of how the infection is transmitted, of the specific causal agent or agents, nor of the exact nature of the disease.

The name "Influenza" itself is vague and meant literally "an influence". It is derived from the mistake of an anonymous historian, who, attempting to read an Italian treatise of the 17th Century, thought it was the name proposed for the disease or group of diseases. However, until much more is learned of the nature of influenza, it has seemed advisable to adhere to this mediaeval name.

EPIDEMIOLOGY

The history of epidemic influenza is truly remarkable for records of epidemics go back to the 10th Century. The peoples of all countries have been visited periodically. At least eight pandemics with their preceding and succeeding epidemics are known. The last great pandemic in 1918 swept Europe causing widespread loss of life. According to Stallybrass,¹ the epidemic of 1918-1919 killed more persons than wounds or other sicknesses together caused among the soldiers of World War I.

The 1941 epidemic in this country seems to

have started in the Pacific region, the virus apparently having been brought to the West Coast by the U. S. Fleet from the Hawaiian Islands where influenza had been epidemic in September, 1940. This epidemic marched eastward from California, spreading into the North and South Central States, reaching the Atlantic seaboard by January. Prior to the outbreak in Hawaii approximately 100,000 cases were reported from Puerto Rico, probably accounting for the increase in the South Atlantic region.

The spread of the 1941 outbreak of epidemic influenza from the West Coast to the East seems to resemble the epidemics of 1928-29 and 1932-33. The pandemic of 1918-19, on the other hand, began in the New England States and travelled westward and southward.

One outstanding feature of influenza is the way in which it changes its character. For years it appears as the mildest of diseases, occurring sporadically and with a low mortality. Then with little warning, it suddenly strikes with terrific force, sweeps the entire world and kills millions of people in a short time. Then it subsides, and when all danger seems past it strikes again with greater violence and higher mortality for a second and even a third time. Each pandemic typically presents three such successive waves, separated from each other by a distinct interval of time.

Evidence accumulated during the pandemic of 1918-19 indicates that influenza is endemic throughout the world and that great pandemics may arise from any focus or even perhaps more or less simultaneously from two or three. Thus in 1918 it appeared simultaneously in Boston and Bombay.

Other characteristic epidemiologic features are the great rapidity of spread, the very high attack rate, the short duration of the waves and the occurrence of more or less localized epidemics of decreasing severity in the years following a pandemic. The morbidity during pandemic periods is very high: between 200

1. Stallybrass, C. O.: The periodicity of Influenza. *Lancet*, 1:372, 1920.

and 400 per thousand persons. Duration of the first wave is from three to six weeks. The second wave lasts longer and the third wave lasts still longer, from eight to ten weeks.

ETIOLOGY

Many different agents have been hailed as the cause of influenza. The bacillus isolated by Pfeiffer in 1892 was long regarded as the specific agent. Yet the Pfeiffer bacillus is present in certain non-influenzal conditions. In the severe epidemic of 1918, Pfeiffer's bacillus could not be found in many cases. This organism is widely distributed and can be found in the throats of many healthy persons, as well as in the bronchi of those with tuberculosis and other pulmonary diseases. Inasmuch as the *Haemophilus Influenza* (Pfeiffer bacillus) has not conformed to requirements for establishing it as an etiologic agent, other bacteria were offered from time to time as more likely causes. The most thoroughly considered of the substituted bacteria were *Bacterium Pneumonitis* and the so-called Pleo-morphic *Streptococcus*, neither one of which satisfied the demands, even so well as the Pfeiffer bacillus.

In 1933, an etiologic agent was discovered that satisfied certain essential criteria. In that year, Smith, Andrews and Laidlaw² recovered from the throat washings of patients with influenza a filterable virus definitely pathogenic for a new experimental animal (the ferret) and demonstrated that antibodies against the virus was produced during convalescence from the disease. This discovery was confirmed by Francis³ and later by many other investigators in other parts of the world. The brilliant work of British and American investigators in this discussion forms a beautiful chapter in the history of respiratory diseases.

Although there is no reason to doubt that this virus has caused many epidemics since 1933, there is equally good evidence that this virus has not caused all the epidemics of influenza for the past seven years. Large epidemics have been studied by Francis³ and Andrews²

in which they failed to isolate the virus originally discovered by the latter in 1933. Therefore, because some epidemics are caused by a known virus and others are of unknown cause, it seemed advisable within recent months to adopt a more exact terminology.

NOMENCLATURE

The workers associated with influenza research at the Laboratories of the Rockefeller Foundation and at the National Institute of London have agreed to use a nomenclature exact enough to be consistent with present knowledge and flexible enough to permit logical expansion as additional facts are acquired. The suggested nomenclature is divided into (1) Clinical Influenza and (2) Influenza A.

Clinical influenza is an etiologically indefinite symptom-complex long recognized by physicians. It includes the symptom-complexes referred to as "febrile catarrh", gripe, common cold, some forms of tonsillitis, etc.

Influenza A is the specific disease caused by infection with any strain of the virus discovered by Smith, Andrews and Laidlaw.²

The separation of Influenza A from Clinical Influenza leaves a group of diseases clinically resembling "A" but of still unknown etiology. If other viruses are isolated from this group and shown to be etiologically related, other specific disorders in the group could be labelled Influenza B, C, D, etc. Within the past year another type of virus was isolated by Francis during an epidemic early in 1940 and according to the classification suggested, outbreaks caused by this virus are to be designated "Influenza B".

In 1936, Shope⁴ showed that swine influenza, the so-called "hog-flu" of the veterinarians, is caused by a combination of a filterable virus and a visible bacterium, the latter having the biologic characteristics of *Haemophilus Influenza* (Pfeiffer bacillus). When given separately to pigs, the virus produces only an attack of "swine fever" accompanied by a mild catarrhal condition; while the bacillus, when administered alone, also has only a feeble pathogenicity. However, the combination of virus and the bacillus produces a severe influenza, with a pneumonia similar to that observed in man

2. Smith, W.; Andrews, C. H., and Laidlaw, P. P.: A virus obtained from influenza patients. *Lancet*, 2:66-68, 1933.

3. Francis, Thomas, Jr.: A new type of virus from Epidemic Influenza. *Science*, 92:405, Nov. 1, 1940.

4. Shope, R. E.: The influenza of swine and man. *Medicine*, 15:453-487, 1936.

during the pandemic of 1918-1919 and with a correspondingly high mortality. The similarity of Shope's findings with what is known of the bacteriology and epidemiology of human pandemic influenza, added to the fact that the disease in swine, first recognized during the 1918-1919 epidemic, has recurred annually since then, lends support to his theory that the swine disease took its origin from man in 1918. These findings also suggest that the severe and highly fatal form of human influenza may be of complex etiology.

Some epidemics of Clinical Influenza are still of unknown cause. Yet I feel safe in saying that the correlation of the epidemiologic, laboratory and clinical data will soon facilitate the differentiation between true influenza and the host of similar upper respiratory infections.

CLINICAL ASPECTS

There is a tendency to call almost any illness influenza. When the chief phenomena are fever of a few days' duration, together with the symptoms of malaise, generalized aching, and perspiration without objective evidence of local disease, it is seldom possible, except during epidemics to establish such a diagnosis clinically. "Influenza" has come to mean almost any fever for which no other name can be found. There is no clinical criterion by which the infection may be recognized. Nor do we know the relationship between influenza and ordinary cases of so-called "catarrhal fever",

"common cold" or "grippe". It is to be hoped that a laboratory method of diagnosis will become available in the future. The present methods involve study of acute phase and convalescent phase serum by mouse protection or complement-fixation tests to determine whether specific virus-neutralizing or complement-fixation antibodies have developed.

SPECIFIC PROPHYLAXIS

The discovery that influenza may be caused by a virus gave hope that a vaccine might be developed for its prevention. While there is at present no specific prophylaxis of value for the prevention of influenza in man, it has been shown by Smith, Andrews and Laidlaw² and by Francis³ that animals can be successfully immunized against the experimental disease and that protective antibodies develop in blood serum of human subjects following subcutaneous injections of influenza culture virus. However, no vaccine yet exists which can give a reasonable chance of preventing influenza.

Although it is not yet possible to put forward many practical suggestions for the control of the disease, much data has accumulated, which, though not conclusive, has shed considerable light on its etiology. The disease has only recently been yielding to serious experimental attack. The prospects for the prevention and control of epidemic influenza are considerably brighter today than they were a decade ago.

565 Newark Avenue

ROENTGEN TREATMENT OF LOBAR PNEUMONIA

Roentgen therapy was employed to the exclusion of specific drugs or sera in the treatment of 34 cases of lobar pneumonia with a resulting mortality rate of 6.2 per cent. Roentgen treatment produces a typical clinical reaction in lobar pneumonia, characterized by relief

of pain, fall in temperature, dramatic improvement in the patient's general well being, decrease in leukocytosis and finally resolution of consolidation.—E. B. Settle. *Am. J. Roentgenol.*, April, 1941 (Clinical Abstracts).

RHEUMATIC INFECTION IN CHILDHOOD

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From the Department of Pediatrics, Jefferson Medical College and Hospital

The incidence of rheumatic infection in childhood is definitely on the increase, in our environment at least. This cannot be attributed entirely to the fact that more cases are recognized than formerly because of better diagnostic acumen, but that there are more actual cases. This means that we must face the situation of crippling, economic enfeeblement, and a possible shortening of the life span, rather than an early high mortality. All of this is our medical problem that must be met with a therapeutic armamentarium that, to say the least, is weak, and to say the most, is being bolstered with the greatest of difficulty because of psychological handicaps, lack of complete information, and no powerful specific.

CAUSE

The cause of the disease has not been established. The bacillus of Poynton and Payne, various strains of streptococci, mystical diplococci, virus infection, and that Atlas of medical etiology that would bear all the world's ills,—*allergy*,—have adherents that claim irrefutable evidence proving their field as the causative factor.

The disease is an *infection*. The cause is not known. The original portal of entry seems to be through the upper respiratory tract and largely through the pharynx and sinuses. Other portals of entry are probable but not as outstanding.

Our own experience does not attach much importance to the tonsils *per se*. In fact, in a completely tonsilectomized population we have had a greater than two per cent incidence as against one and eight-tenths per cent incidence in a non-tonsilectomized group, and a flat two per cent incidence in the general mixed population. This, of course, refers entirely to initial attacks. We have been impressed with the accuracy of the observation of Colbourn¹ who

declared that susceptibility to the disease was hereditary strictly as a Mendelian dominant.

CLIMATE

The geographic distribution indicates a possible reduction of resistance in susceptibles where such climatic conditions as dampness, and lack of sunshine are likely to occur. London, Glasgow, and Edinburgh regularly report the highest incidence. In the United States the northeastern coast, and for two or three hundred miles inland, is the area most greatly affected. This does not mean, however, that the remainder of our coastline is a rheumatic's paradise. New Orleans in the South and the West Coast are certainly not free. Arizona and New Mexico are in a very favorable climate. The Gulf Stream seems to give Puerto Rico, the Virgin Islands, and Bermuda a freedom from the disease akin to that of the tropics. The speed with which the disease is arrested in these islands is nothing short of miraculous.

PATHOLOGY

Pathologically two lesions are found. First, the proliferative, recognized as the rheumatic nodule, or Ashoff body, and second, the exudative or inflammatory.

The proliferative lesion follows the arterial blood supply and the greater the supply the more numerous the lesions. However, they are found sometimes in great numbers even in the connective tissue of the extremities as palpable nodules. One can visualize in the mind's eye even more of them in the heart and larger arterial blood vessels.

The exudative lesion does not seem to be a factor in the production of recurrences but it has another clinical aspect that must be taken into account, particularly in children. This lesion is a comparative rarity in the synovial membranes of young children but may be seen

1. Colbourn: Mary Scott Newbold Lecture, 1940, in press.

in older children in whom it might not necessarily be found about multiple joints. The pericardium and peritoneum are frequent sites in young children. The pleura and meninges are less commonly involved. Appendicitis has often been a diagnosis made in error because of lack of completeness in physical examination and when operated upon, the appendix and cecum are found to be streaked with a few hyperemic vessels and a number of large mesenteric glands are present. Microscopic changes in the peritoneum would also be found if sought. Free fluid in the abdomen in small quantities is not uncommon.

Up to very recent times rheumatic infection was said to never, or very rarely, occur in children under five years of age. This was due to the almost universal insistence that joint pain and swelling, and acid sweats were the outstanding symptoms of the disease. Infants and young children do not have the joint involvements, and it is extremely rare that any child under puberty has acid sweats. Nosebleeds in any child, unless otherwise classified, should be regarded as possibly rheumatic in origin. Pharyngitis at the outset is an extremely common occurrence. Other evidences of acute upper respiratory infection are present with or without this pharyngitis. The younger the child the higher will be the temperature range, and the more acutely ill will the patient be from the very beginning of infection. The severity of this onset, it must be borne in mind, may vary from the mildest evidences of infection, and this is particularly true in the older child.

CHOREA

Chorea in childhood is a central nervous symptom of rheumatic infection which is quite frequently found with, or without, one or more of the foregoing pictures. Autopsy sometimes shows a "wet" brain, or nothing except small rheumatic nodules in connective tissues about the arteries. Palpable rheumatic nodules on the extremities, and even on the head, may be found in any case. In the last few years they seem to be more common in cases about Philadelphia than formerly. In the British Isles they have always been a prominent characteristic,

and are generally described as larger than most of those found in our local experience. It is my opinion that cases presenting these in any numbers are more severely stricken and are slower to recover from their exacerbation. The erythrocytic sedimentation rate is always rapid in rheumatic infection and remains so as long as the disease is active.

GROWING PAINS

A word about "growing pains". Myalgia may occur in other conditions than rheumatic infection. While painful limbs in infants are more likely to be due to scurvy or epiphysitis, the older child, particularly the anemic and readily fatigued, should be carefully examined further for rheumatic infection.

THE HEART

The heart in rheumatic children is always involved. It is evidenced by an increase in rate, a diminution in muscle tone, and sometimes a murmur. Percussion may or may not elicit enlargement. In infants an embryocardiac first sound may be the first evidence of cardiac disturbance. In older children a lack of muscle tone or a muffling of the first sound replaces it. If dilatation is sufficient and relaxation of the A-V rings occurs a systolic murmur at the apex will be heard. These signs are caused by rheumatic nodules and toxins. A nodule occurring in the A-V bundle gives rise to heart block, thereby changing the usual picture of rapidity.

As the condition progresses, an exudative lesion may involve the endocardium and the pericardium. Occasionally, and certainly in untreated cases, permanent damage may be done the heart valves, particularly the mitral and aortic. Decompensation rarely if ever occurs in primary attacks. In children under puberty decompensation rarely occurs without an active rheumatic episode. In adolescence the reverse is often true. We believe that a diagnosis of functional murmur, hemic murmur and so forth is made far too frequently in young children.

As can be deduced from the foregoing, actual permanent damage need not be, and happily is not, present in a child's rheumatic heart;

but the potential, or that which makes for a crippled heart, is as surely laid down as the foundations of a building. The term endocarditis has no place in childhood except in the bacterial endocarditis, which is fortunately rare even as an aftermath to rheumatic infection at this age. One must pass up the picture of endocarditis as it is handed down from adult practice and visualize this broader and more inclusive picture of carditis. Here there is some chance, and a great chance, to prevent heart damage with its subsequent invalidism or crippling. This is what should be meant, for the time being at least, when one speaks of heart disease prevention, since we have no prevention for rheumatic infection *per se*. This is undoubtedly more desirable than what might be more properly termed "heart salvage", which is certainly more accurate for what is now practiced as "heart disease prevention" by the cardiologist.

Electrocardiographic studies are barren of diagnostic aid to date in rheumatic infection in children. Even in the late case where evidence of damage is pronounced, and in cases of decompensation, the studies give no clues and no help.

PREVENTION

From the standpoint of prophylaxis the increasing incidence of this disease merits greater investigative attention. All persons subject to the disease cannot retreat to the middle of the Atlantic permanently, and there is no specific that could be used on a large scale for the general population. The approach to the problem as far as we can go at present is to preach good housing, proper heating and air-conditioning apparatuses, and proper clothing. Not only is the damp house objectionable, but the overheated, dry house from which an individual goes into dampness and probably wearing inadequate clothing is a menace. When air conditioning provides warm, reasonably moist air at a temperature of approximately 68° to 70° Fahrenheit, and the air not supersaturated but with a high percentage of moisture, the individual can then wear reasonable clothes that will protect the body without undue weight, and permit of additional garments for out-of-

door use that would not therefore need to be bulky and burdensome.

FEMALE CLOTHING

Female clothing today could be classed as barbaric except that it does not have any of the utilitarian advantages comparable with the costume of the savage. Milady dresses the children, and therefore their shoes do not fit. They are instead pretty. Their legs are freezing from the ankles to the groin. Their arms are bare and they probably have too many layers of wool across the chest. Legs and arms should be protected. This will maintain a more equable heat throughout the circulation, and not throw an additional burden upon heat control centers, the heat-producing factors, and the cardiovascular distribution center. These conditions must be gone into fully and have the support of the public if we would help solve the rheumatic problem.

TREATMENT

The treatment of the attack begins, as it always has for years, with rest,—complete rest in bed with no bathroom privileges, reading, or radio diversions, or other stimulating or exciting features. The patient should not be permitted to sit up.

The diet should be composed of a high carbohydrate and a low fat content.

Therapeutically there should be administered from five to ten grams (one to two drams) of sodium salicylate, together with sodium bicarbonate in equal or larger quantities, every twenty-four hours in divided doses.

Attention to the diet in carbohydrate-fat relationship and the administration of bicarbonate of soda rarely fails to prevent vomiting. This vomiting is due to ketosis and not to gastric irritability. Unlike Cecil,² who feels that acetalsalicylic acid might be substituted in cases of vomiting with good effect, our patients very clearly indicate that, while acetalsalicylic acid would affect the exudative lesion favorably to a limited degree, the salicylates are so mildly specific that large doses are necessary in order to get any real benefit therefrom. The

2. Therapy of Rheumatic Fever: Cecil, R. L.; J. A. M. A., Vol. 114, No. 15, p. 1447, April, 1940.

best way to do this is outlined above, and then one may expect some little help not only in overcoming the pain in exudative lesions, but some assistance in bringing about a period of quiescence by direct or indirect action on the proliferative lesions or the causative factor directly. The use of aspirin is like sending a small boy on a large man's errand.

CONVALESCENCE

The treatment must be continued until quiescence is established. The following criteria are used for determining quiescence:

1. Consistently normal temperature.
2. A normal pulse rate.
3. Complete cardiac compensation and no dilatation.
4. No muscular pains or serous membrane activity.
5. Erythrocytic sedimentation rate no faster than twelve at the end of two hours.

In our last 150 cases these postulates were arrived at in five cases in one month's time, and in three cases after six months. The average is two and one-half to three months.

REHABILITATION

Rehabilitation may now be started. Daily massage is given and its effect on the pulse rate noted. If there is no change, or it returns to normal in a few minutes, then the patient may be lifted out of bed and permitted to take five or six steps. The patient is again lifted back into bed and the pulse rate noted. If it returns to normal in a few minutes, the procedure can be repeated the next day with an increase in the number of steps. As long as the pulse rate returns to normal in two minutes after exercise, this procedure can be lengthened from day to day until the patient is walking about on a level with comparative freedom.

In anticipation of his going up and down stairs, the child may be permitted to get in and out of bed alone, and its effect noted. Consider a few steps on a stairway each day; they are soon added to the routine. If the pulse and temperature behave well throughout this program, further extension is permissible. In one month the child is reasonably active and then its athletic training can be very carefully

started. If at any point the pulse or temperature do not behave as they should, rest is indicated and a fresh start made when they return to normal. Competitive sports cannot be considered in growing children until well after puberty and only if no exacerbations have intervened. Swimming is logically taboo permanently.

One can generally prophesy an exacerbation during the spring following a primary attack under ordinary conditions. However, with the above care, plus the administration of full doses of the salicylate of sodium and bicarbonate given throughout the first week of every month, for at least a year, an impressive reduction in exacerbations is noted. It is also found that vomiting does not occur when these "prophylactic" treatments are given.

When exercise is first started, iron tonics help. The syrup of the iodide of iron, alternated with ferrous sulphate or ferrous carbonate from time to time, speeds convalescence.

It is important to note that rheumatic infection is "arrested", not cured. A cure cannot be assumed under five years and since the infection does not provide an immunity as in the exanthemata, re-infection may occur in later life. Antistreptococcic vaccines are futile as specifics, and more frequently do grave harm.

MANAGEMENT OF CHOREA

The management of chorea as a manifestation of rheumatic infection deserves a special word. Care should be taken in the diagnosis of chorea since athetoid movements, tics, ataxias, and so forth have led to incorrect diagnoses. Ninety per cent of true choreas will be found under the age of fifteen years and some other evidence of rheumatic infection can always be found if sufficient care is taken in the search for it.

It is curious to note how the severity of chorea varies in different communities. It is said that in Boston the attacks are so mild that no serious consideration is given them. Yet in New York and Philadelphia they vary from the very mild to the maniacal. The latter cases are undoubtedly benefited by lumbar puncture and the reduction of third circulation pressure.

Sedatives are of little help. Sodium bromide is the best. Phenobarbitol, the psychiatrist's bathroom cabinet cure-all, is ineffective. Nirvanol, because of its toxicity and fairly high percentage of failures, is no longer used.

FEVER INDUCTION

Fever induction stops the attacks with a fair degree of promptness. Diathermy is practiced by the physiotherapists and gives excellent results in older children who can be controlled. The younger children and the uncontrollable older ones respond well to fever induction by means of the intravenous use of mixed typhoid-paratyphoid vaccine. The technic is as follows:

Three and one-half hours following a light breakfast a hypodermic injection of morphine sulphate is administered, the dose depending upon the weight and age of the patient. One-half hour later, an intravenous injection of 0.2 c.c. of a mixed typhoid-paratyphoid vaccine is given. To each c.c. there are five hundred million typhoid and two hundred fifty million each of paratyphoid A and B in the preparation used. Special preparations on the market with proteins removed are not as effectual as the regular stock vaccine.

The patient is wrapped snugly in blankets. An experienced nurse attends the patient and the temperature is taken at ten-minute intervals. A temperature of at least 104° F. must be obtained for the best results, and remain there for two hours. If it tends to go over 105° F., the patient should be removed from the blankets and the temperature allowed to come down. If it does not rise to 104° F., a second intravenous injection of the same dose should be given as it descends. When the patient is out of the blankets he is ready for a hearty lunch.

Daily treatments for eight days constitute the course for the average child. In the event that the original dose has not induced the desired temperature, the next day the dose is

increased 0.1 or 0.2 c.c. In the exceptional case it has been necessary to give as high as 1.5 c.c. for the eighth treatment. Marked improvement is noted after the third or fourth treatment. In instances where the temperature has gone to 106° F., it has been noted after one treatment. A few have residual minor evidences after the eighth treatment which seem to clear up entirely after a week's rest.

Two patients alone showed untoward reactions. Their temperature rose to 107° F. with extreme rapidity, accompanied by evidence of collapse. Adrenalin hydrochloride 1:1000 in two to five-M doses, and an ice water enema gave prompt relief. The adrenalin hypodermic is prepared and ready for use at all times that the patient is under active treatment. There has been no evidence of any deleterious after-effects following fever induction in any of our series.

RESULTS

It is our experience in 300 cases of rheumatic infection, with or without chorea, that exacerbations are markedly reduced in number by the technic described. We are impressed with the increasing value of improved technic in the procedure in more recent cases. It will, however, require another five years of work and observation to reduce this to mathematical terms. The marked difference in older methods or lack of methods is emphatic in its demonstration of improvement.

It must be borne in mind that the child with a crippled heart is more of a cripple than even the poor unfortunate with a withered limb. The latter at least has a potential economic future. The child victim of heart disease looks forward to a curtailed life, generally no economic future, and ofttime lives on borrowed time and that most likely at the community expense. Anything that ameliorates this situation deserves consideration until something really better can be found.

SEPTIC ABORTION AS A CAUSE OF MATERNAL MORTALITY IN
NEW JERSEY

MATERNAL WELFARE ARTICLE NUMBER SIXTY-THREE

By ARTHUR W. BINGHAM, M.D., East Orange, N. J.

Chairman, Committee on Maternal Welfare of The Medical Society of New Jersey; and
Chief Advisory Obstetrician, Bureau of Maternal and Child Health,
State Department of Health

This is the third article on New Jersey Maternal Mortality Statistics.

The mortality rate for septic abortion in 1940 was 6.3 per 10,000 live births. The rate for deaths from abortion, where there was no mention of sepsis, was 0.5 per 10,000 live births.

It will be a surprise to many to know that in 1940 there were more deaths from septic abortion than from any other classification of maternal deaths. There were 37 deaths from septic abortion which, added to three deaths from hemorrhage, makes a total of 40 deaths due to abortion. Puerperal sepsis caused 24 deaths, toxemia of pregnancy 25, puerperal hemorrhage 18, and other accidents of child-birth 34 deaths. These are the five main classifications of maternal mortality.

This large number of deaths from abortion demands further study. Until 1940 deaths from criminal abortions were classified as homicides; now they are classified as maternal deaths. We cannot change the international classification but can we not reduce the number of cases? Further education is needed.

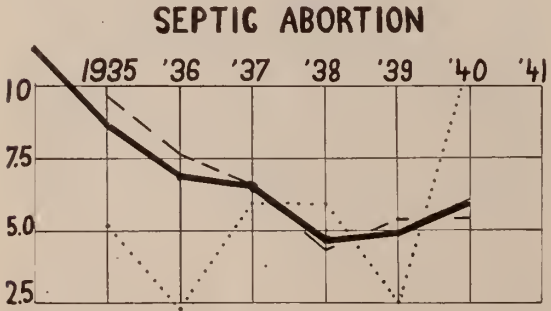


FIGURE 16

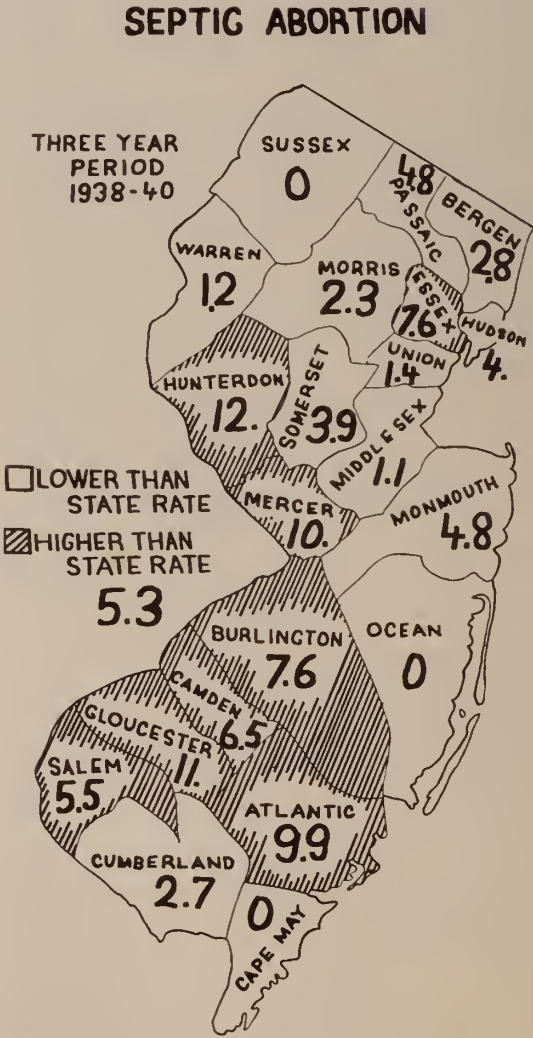


FIGURE 6

This group of deaths includes several types of abortion. Self-induced and criminal abortions make up the greater number but a few accidental and therapeutic abortions also became septic.

PUBLIC EDUCATION

The public must learn that abortions are dangerous. The physicians should educate their patients in this field. Physicians as well as the public often treat abortions too lightly. This is clearly shown in the incompleteness of the histories on deaths from abortions. The lack of important facts in most histories makes impossible a detailed study of this large group. If the public understood the great danger and if more physicians treated these cases seriously there would be fewer deaths.

A patient with an accidental abortion should rarely die if she called a physician early and if she received the proper treatment. Some of the cases are apparently complicated by an improperly performed dilatation and curettage.

Criminal and self-induced abortions are always dangerous as a large number of them become septic. While they do not all die, in many cases the patient is handicapped by some complication. They should never occur.

TREATMENT

Therapeutic abortions should be done only after careful consultation regarding the necessity of the operation. Remember, that then patients sometimes die.

The treatment of a septic abortion demands skillful care. While it is generally known that patients in abortion should not be curetted, 10 out of the 37 who died had been curetted after they had become septic. The alcohol drain treatment for septic abortion as devised by Dr. E. J. Ill* has been mentioned several times in the *Journal of The Medical Society of New Jersey*. It was first used in puerperal sepsis but is especially valuable as a treatment for septic abortion.

In 1940, five counties had no death from septic abortion and it will be seen on the map (Figure 6) that three counties have had no deaths in this classification in three years. Perhaps they can teach us something about reducing the rate.

If deaths from septic abortion were reduced 50 per cent there would be a marked reduction in the total maternal mortality rate. Why not try?

144 Harrison Street

A LESSON FROM A DEATH CERTIFICATE

NUMBER THIRTY-FOUR

Patient, seven months pregnant, treated for menopause. Diagnosis later changed to placenta previa.

Examined vaginally by one or more physicians in the home.

Sent to hospital. Cesarean section followed by general peritonitis and death.

Some of us believe that a patient with suspected placenta previa should not receive a

vaginal examination until she is prepared as for delivery in a hospital and examined in the delivery room with all sterile precautions and everything ready for packing, bagging, or delivery.

A. W. BINGHAM, M.D.

* Described in the Lesson from a Death Certificate, No. 4, page 739 of the December, 1938, *Journal of The Medical Society of New Jersey*.

RELATIONSHIP BETWEEN THE MEDICAL PROFESSION AND THE HOSPITAL *

By ELLIS L. SMITH, M.D.,

Superintendent and Medical Director, Essex County Isolation Hospital, Belleville, N. J.

The relationship between the public general hospital and the physician has been and will continue to be an agreeable one. If there is to be continued progress, this relationship must, of necessity, exist. During the last two or three decades, changes have come about whereby no longer does a single physician or a small group of physicians dominate a hospital, except in very rare instances.

The hospital has become a complex organization with experts in each department, as administrative, financial, nursing, social and technical, to mention only a few. The position of the medical staff of the hospital is one of respect and influence. It controls the quality of the medical work carried on and the ethics practiced. Difficulties involving the medical staff are minor and therefore easily adjusted, except for that occasional clash of personalities.

The relationship between the tax-supported hospitals, that is the State, county and municipal, and the profession, is also an agreeable one. *However, there should be no further encroachment upon the physicians' domain by these agencies.* There has been a tendency in recent years for these public hospitals to have some private accommodations. In these instances it is important that the hospital administration impress upon the patient that the selection of their own physician is a privilege, and must be paid for.

As the profession is placing more and more emphasis on teaching, more clinical facilities are being sought for students, and more clinical material is needed for graduate teaching. It would be reciprocally advantageous for these hospitals to be organized on the basis of affiliation with a medical school. Thus, the staff physician would be partly repaid for his services by having clinical material available

for teaching and the hospital would be benefited by improved medical care of its patients.

Some physicians (those of the *prima donna* type) are wasteful of supplies and material. They recommend the purchase of some new gadget that may or may not prove practical. There could be a saving in their handling of surgical instruments. The routine ordering of laboratory work with repeated tests, just because it is available at a flat rate, is inefficient. Hospital pharmacies are notoriously overstocked with proprietary preparations, which are, for the most part, no more efficient, but much more expensive than drugs and compounds listed in the Pharmacopoeia and the National Formulary.¹

Another improvement would be the repeal of the Act that requires an intern to secure a certificate of eligibility before he may accept a position in a New Jersey hospital.² Such a procedure merely means more red tape. Hospital administrators and Intern Committees of the Staff accept and are guided by the regulations set up by the Council on Medical Education and Hospitals of the American Medical Association.

As our National Defense program proceeds, some hospitals are beginning to have difficulty maintaining non-technical employees. If this situation continues to grow worse, the profession can assist the hospitals by preparing their patients prior to their admission, for the fact that certain luxurious details of service might be curtailed.

For better service to our State and community, let us think less of the intricacies of relationships and organizations, and let us unite with a clear and distinct vision of the purpose of our existence: namely—"The Care of Our Patients".

* Read May 21 at Annual Meeting of The Medical Society of New Jersey.

1. The *Journal* would appreciate comments from physicians on this point.

2. This act has been recently modified by repealing the provision that the intern must pay a fee for registration.

STATE SOCIETY ACTIVITIES

WELFARE COMMITTEE

The Welfare Committee of The Medical Society of New Jersey met in Trenton on Sunday, September 14, 1941, at 2:00 p.m. The Chairman, Dr. Hilton S. Read, presided.

The Chair described the constitutional functions of the Welfare Committee, and called on President Lewis, who stressed the rôle of each member of the Committee as a representative of his county society.

Dr. Lance presented the report of the Medical Service Administration (see page 535).

Dr. R. L. Sharp reported for the Sub-Committee on Medical Practice and its several advisory committees (see page 534).

Dr. C. M. Robbins gave the report of the Sub-Committee on Public Relations (see page 530).

Dr. Stanley Nichols reported for the Sub-Committee on Public Health (see page 533).

Dr. B. S. Pollak presented the report of the Sub-Committee on Legislation (see page 531). He paid special tribute to the achievements of the Executive Secretary of his Committee, Dr. Frederic J. Quigley, through whose efforts a better relationship between the Society and the legislators has been established.

Dr. Samuel Barbash, President of the State Board of Medical Examiners, outlined the duties of the State Board, and pointed out that the New York State Board of Medical Examiners had under consideration a plan to deny reciprocal licensing to holders of New Jersey licenses. He stated that the New Jersey Board might find it necessary to adopt a similar attitude and refuse license without examination to holders of New York State licenses.

Dr. Quigley discussed the status of health legislation now pending before Congress.

Dr. Davidson asked the endorsement of the Public Relations Committee program and was notified by the Chairman that such endorsement was given by the House of Delegates at the Annual Meeting.

On motion made by Dr. Van Ness, the enlargement of the Welfare Committee from 35 to 45 members by the President was approved.

Dr. Schlichter then gave the report of the Medical Preparedness Committee (see page 537).

Dr. H. V. Hyde, representing the Civilian Defense Council, discussed the need for studying the problem of handling casualties, supply-

ing nurses, and offering first aid training throughout the country. He reported that the Civilian Defense Council hoped that a Chief of Medical Service be appointed in every community. This official would be expected to take inventory, to stimulate the establishment of emergency field units, to prepare a spot map showing hospital and medical resources of the area, to promote the schooling of nursing aides, and to encourage the training of the people in first aid.

In answer to a question asked by Dr. Comando, Dr. Hyde indicated that it was hoped Congress would appropriate money to furnish equipment for civilian defense purposes.

On motion made by Dr. Comando the Legislative Committee was instructed to call to the attention of the State Board of Medical Examiners, the importance of considering the status of foreign medical schools before admitting their graduates to examination.

The Committee rose at 4:00 p.m. Following is the role of attendance at this meeting:

ATLANTIC

Dr. Hilton S. Read, Chairman

CAMDEN

Dr. Thomas K. Lewis, President

Dr. Henry B. Decker Dr. George B. German
Dr. Reuben L. Sharp

CAPE MAY

Dr. Clarence W. Way

CUMBERLAND

Dr. Millard F. Sewall Dr. H. Burton Walker

ESSEX

Dr. Harry N. Comando Dr. Royal A. Schaaf
Dr. Charles M. Robbins Dr. H. Roy Van Ness

GLOUCESTER

Dr. Chester I. Ulmer

HUDSON

Dr. Reeve L. Ballinger Dr. Berthold S. Pollak

HUNTERDON

Dr. Samuel B. English

MERCER

Dr. D. Leo Haggerty

MIDDLESEX

Dr. Jacob J. Mann

MONMOUTH

Dr. Stanley Nichols

OCEAN

Dr. J. Edwin Obert

PASSAIC

Dr. Sigurd W. Johnsen

SOMERSET

Dr. Frank L. Field

UNION

Dr. Norman W. Burritt Dr. Frederic W. Lathrop
Dr. Herschel S. Murphy

WARREN

Dr. William H. Varney

ADVISORY

Dr. Frederic J. Quigley Dr. Robert P. Fischelis
Dr. Samuel Barbash Mr. Wm. H. MacDonald

STAFF

Dr. LeRoy A. Wilkes, Executive Officer
Dr. Henry A. Davidson, Editor

TRUSTEES

Dr. Elias J. Marsh Dr. Ralph K. Hollinshed
Dr. Samuel Alexander

GUESTS

Miss Margaret Ashmun Dr. Samuel R. Hughes
Dr. Frank A. Bien Dr. H. V. Hyde
Dr. Chester R. Brown Dr. A. E. Jaffin
Dr. Louis K. Collins Dr. Elton W. Lance
Dr. George F. Dandois Dr. Joseph R. Morrow
Dr. William E. Dodd Dr. Ellen C. Potter
Dr. M. L. Griswold, Jr. Dr. Charles H. Schlichter

TOWN HALL

The Academy of Medicine of Northern New Jersey is one of twenty civic organizations sponsoring a series of forums which meets at the Mosque in Newark. Subscriptions are \$3.30, \$4.40, or \$5.50 per series. Checks should be forwarded to Town Hall, 605 Broad Street, Newark, with a memorandum "Credit to the Academy of Medicine".

The first forum will be on November 3, at which Major George Fielding Eliot, Paul Schubert, Major Alexander P. deSeversky and Wythe Williams will discuss "Propaganda and the World at War".

Sinclair Lewis and Lewis Browne will lead the forum on November 17 to the theme of "It Can't Happen Here".

Leslie Howard, the screen star, will speak in December on "England Under Bombs".

On January 14, 1942, Clare Booth, the distinguished playwright, will open a discussion of "America Re-orient Herself".

The Town Hall will close on March 30 with a "Correspondents' Round Table" headed by Vincent Sheean, William Shirer and Edward Tomlinson.

A proportion of the subscription fee will be given to the Academy of Medicine for its general fund if you will indicate that you are subscribing through the Academy.

Further information may be secured from the Academy's Project Chairman, Dr. E. LeRoy Wood, 160 Roseville Avenue, Newark.

SUB-COMMITTEE ON PUBLIC RELATIONS

The Sub-Committee on Public Relations met on Sunday, September 14, 1941, at 11:15 a. m. at the Stacy-Trent, Hotel, Trenton.

Present were: Drs. Robbins, Chairman; Schaaf, Collins, Dandois, Hughes, Obert, Burritt and Davidson, Secretary. Dr. Lewis was present for part of the time.

Kiwanis Program: The Secretary reported that specific speakers had been assigned to 72 of the 84 Kiwanis Clubs.

The Chair recommended a special training session for the speakers at which the mechanics of the talks would be discussed and the possible questions that might be asked by the audience would be answered. It was agreed to hold the sessions in both Camden and Newark to make the meetings fully accessible.

Clip Sheet: The Secretary proposed the authorization of a brief summary of some of the scientific articles published in the *Journal of The Medical Society of New Jersey* to be written for the laity and released to the newspapers. On motion of Dr. Schaaf, duly sec-

onded and passed, the Secretary was authorized to prepare such a monthly clip, but was instructed not to use the names of the authors of the articles.

Exhibits: The Chair notified the members that some confusion had developed over responsibility for preparing exhibits for the Convention of the American Hospital Association in Atlantic City, September 15 to 20, 1941. When the invitation came in, the Hospital Relationships Committee had arranged with Dr. Frankel of the Hospital Association to set up an exhibit in one booth. The Medical Preparedness Committee asked space, and two booths were assigned. The Medical Preparedness Committee notified the Public Relations Committee that the former would like to arrange for the exhibit. Subsequently, the Medical Preparedness Committee notified the Society that they had arranged with the British Library of Information to secure an ambulance and a moving picture; that it had retained the George W. Brown Company, a professional

exhibit construction agency, to arrange these exhibits at a cost of \$140. The Public Relations Committee was asked to prepare a panel illustrating the rôle of the Medical Society in civilian defense. This was done and the panel was sent to Atlantic City. The Committee was also asked to prepare a poster on the value of medical services to the hospital. This poster was also prepared and forwarded to Atlantic City.

Dr. Scott now reported that when the exhibits were set up, the ambulance was removed from the booth and placed in the lobby of the hall. This left one booth completely empty. It was thus necessary to provide at short notice some material for this empty booth. When Dr. Lewis was informed of the difficulties which arose in connection with the empty booth, he wished to know with whom the responsibility rested.

It was decided that the Public Relations Committee would assume responsibility for exhibits to the laity, but not for technical exhibits to professional groups, since in such cases the Advisory Committees would have access to the material.

Dr. Schaaf suggested that President Lewis be asked to add to the Committee several doctors experienced in the construction of exhibits, and that funds and facilities be provided to set up such exhibits when necessary.

Promotional Booklet: The Chair reported that he had been much impressed with a booklet distributed by the Medical Society of Wisconsin, in which the rôle of that Society as a guardian of public health had been dramatically highlighted by pictographs. The desirability of such a booklet for our Society was discussed.

It was felt that no action need be taken now, but that information should be secured as to possible cost.

Publicizing Committee Findings: The Chair reminded the members of the following part of the report of Reference Committee "B":

"We bespeak for the Public Relations Committee, the coöperation of the various state and county committees in getting newsworthy announcements to that Committee so that attention-arresting publicity may be secured." (P. 11, Transactions.)

Methods of securing these findings, particularly from the Advisory Committees, were discussed and it was agreed that the Public Relations Committee should edit and publicize the appropriate findings of those Committees.

Monthly Health Column: The Secretary was authorized to prepare six health columns to be released to the newspapers at the rate of one a month, with a reëvaluation in six months of the utility of such a column.

Woman's Auxiliary: The Chair reported on a conference between the Chairman and Secretary of the Public Relations Committee, and the President of the Woman's Auxiliary, and the Chairman of the Auxiliary Public Relations Committee. The Auxiliary offered its services in the solicitation of speeches to women's clubs, in the clipping of newspaper items and in the distribution of A. M. A. radio posters.

Speakers' Bureau: County Public Relations Chairmen will be requested to furnish names for a centralized State Speakers' Bureau.

There being no further business, the Committee rose at 12:45 p. m.

HENRY A. DAVIDSON, M.D., Secretary,
Sub-Committee on Public Relations.

SUB-COMMITTEE ON LEGISLATION

REPORTED SEPTEMBER 14, 1941, TO THE WELFARE COMMITTEE

Although the Legislature has not finally adjourned, being scheduled to reconvene November 13th, it is unlikely that any bills still pending will receive further consideration. Hence we are presenting our final report of bills introduced at this session, of especial interest to the Society.

Of the seven bills introduced which would have adversely affected the Medical Practice Act, which could be characterized as vicious, none were enacted into law. As a matter of fact, none were reported out of committee.

A tremendous amount of Federal legislation has been proposed at the current session of Congress of interest to the profession, affecting public health and the practice of medicine. A

digest of these bills and their status in Congress has come to us through the medium of eight Legislative Bulletins from the Bureau of Legal Medicine and Legislation of the American Medical Association. (A copy of one of the more recent bulletins was sent to every member of the Welfare Committee.)

It is appropriate to mention the fact here that we have received excellent coöperation and assistance on several matters which were under study, both from the Director of the Bureau of Legal Medicine and Legislation and also from the Secretary of the Council on Hospitals and Medical Education.

Following is a summary of the disposition of bills during the 1941 legislative session:

BILLS AFFECTING THE MEDICAL PRACTICE ACT

Assembly No. 4. Repeals in its entirety the Uniform Medical Practice Act enacted in 1939.

Referred to the Committee on Public Health and subsequently transferred to the Miscellaneous Business Committee. This committee is usually referred to as "the morgue".

Assembly No. 339, Senate No. 92. Both of these bills would permit certain individuals, graduates of Class C schools, to take the examination for licensure to practice medicine.

A-339 was transferred to the Miscellaneous Business Committee. S-92 remained in the Committee on Public Health of the Senate.

Assembly No. 353. This bill would make mandatory the conferring of the degree of "Doctor of Medicine" upon a group of osteopaths having full licenses to practice medicine and surgery.

The bill was transferred May 19th to the Miscellaneous Business Committee.

Senate No. 156. This would grant a license to practice medicine and surgery to an individual who held a license to practice osteopathy in the District of Columbia.

It was referred to the Committee on Public Health, and pressure was exerted on the chairman of the committee to report the bill. As the result of a conference with the introducer of this measure, Senator Schroeder, attended by Drs. Alexander and Harryman (the latter Senator Schroeder's personal physician), Dr. Chastney, Legislative Chairman of the State Osteopathic Society, and Executive Secretary of this Committee, no further effort was made to have the bill reported out of committee.

Senate No. 190. This bill sought to create a separate Board of Chiropractic Examiners.

It remained in the Committee on Public Health. Last year's chiropractic bill was reported out but received only the vote of the introducer, Senator Stanger, when moved for passage.

Assembly No. 469. Permits graduates of foreign medical schools, recognized by the Board of Medical Examiners, who are American citizens and have been residents of New Jersey for 10 years and who have fulfilled all the requirements of the Medical Practice Act *except the securing of a license to practice in the country in which this school was located from which they graduated.*

This passed the Legislature and was signed by the Governor. This Act was recommended by the Board of Medical Examiners and affects 7 or 8 residents of New Jersey who, because of war conditions, were compelled to leave the foreign countries in which they graduated before they could secure their licenses.

The amendment remains in effect for three years only. A similar provision was made in New York last year.

Assembly No. 38. Provides for a revised and stronger Dental Practice Act.

At a meeting of the Committee on Legislation, Dr. Alexander questioned whether one section would not interfere with the medical profession's right to practice oral surgery. We were assured that the section in question did not interfere with or limit the practice of oral surgery by physicians.

The bill passed the Assembly March 31st and on reaching the Senate was referred to the Committee on Public Health. Not feeling completely satisfied with respect to the section of the bill in question, counsel to the Society, Mr. Wall, was consulted. Mr. Wall was strongly of the opinion that this section of the new Act (45:6-19) abrogated the provision of the present law (45:6-14) as to the right by physicians to treat diseases of the mouth and perform operations in oral surgery.

On submission of the opinion of our counsel, the Legislative Committee of the Dental Society promptly agreed to the deletion of the section in question and to an amendment restoring the wording of 45:6-14 to the bill.

It was agreed that Senator Zink would move the bill with the amendment. The date of reporting the bill out of Committee was June 9th. Endeavors were made by the Chairman of the Legislative Committee of the Dental Society to expedite its passage so that it might go back to the Assembly for repassage with the amendment. It was not until July 28th that the bill was moved for passage. And to our great surprise and chagrin the bill was proposed and passed *without the amendment agreed upon.*

We are of the opinion that its passage without the amendment was not intentional. The Dental Society's legislative committee has volunteered to propose an amendment at the beginning of the 1942 legislative session identical with the one intended to have been incorporated in the passed bill.

Senate No. 428. Provides that all revenues of State regulatory (examining) boards be paid into the State treasury monthly.

This was reported out by the Judiciary Committee on July 14th. We joined with other professional groups in opposition to it. The bill was not moved. County society keymen did very effective work here.

CHIROPODY

Assembly No. 60. sponsored by the N. J. Chiropody Society, would create a separate Board of Chiropody Examiners; extend the educational requirements to include 2 years in a college of arts and sciences and 4 years in a chiropody school; permit almost unlimited privileges in the treatment of any ailment of the foot and leg.

A-257. Continues the licensing of chiropodists by the Board of Medical Examiners; provides for 4 years' high school and 3 years in a chiropody school; defines definitely, though liberally, the scope of practice in the treatment of foot ailments.

These bills were referred to the Committee on Public Health, which reported out a committee substitute for both bills. This incorporated all the features of A-257 (sponsored by the Society) and added certain unobjectional sections of A-60 (sponsored by the chiropodists). May 19th, the committee substitute was recommended to the Miscellaneous Business Committee.

WORKMEN'S COMPENSATION

Assembly No. 167. Establishes "reasonable compensation" for treatment of hernia, instead of the present maximum allowance of \$150. for medical and hospital care.

This passed the Assembly March 31. It was reported out of the Committee on Banking and Insurance of the Senate April 30th. Repeated reminders by influential members of the Medical Society to move the bill were ineffective. Apparently the opposition of one or two corporations was controlling.

PUBLIC HEALTH

Assembly No. 402. Regulated venereal disease control and forbids persons other than licensed physicians to treat venereal diseases.

Assembly No. 408. Forbids advertisement of remedies for, or places of treatment of, venereal diseases.

The attention of the House of Delegates, at its meeting in May, was called to the importance of A-402 as a public health measure. At that time the bill and also A-408 had passed the House of Assembly unanimously. We had been informed that an amendment would be offered in the Senate to A-402 exempting Christian Scientists from its prohibitory features.

After discussion on the floor of the House of Delegates, a motion by Dr. Cosgrove (Hudson), to the effect that the Society oppose any amendment to this bill which would permit anyone other than a licensed physician to treat venereal diseases was unanimously adopted.

Following this a carefully prepared letter was sent to each senator explaining the baneful effects on public health of permitting any group other than licensed physicians to treat venereal diseases. A copy of this letter was sent to all county society officers and keymen. Keymen were urged to interview their senators and enlist their opposition to the proposed amendment.

The bill came to a vote June 23rd. The amendment exempting Christian Scientists from its prohibitory features,* proposed by Senator Pierson (Morris), was adopted by a vote of 13 to 1. Of those recorded as voting, only Senator Summerill (Salem), Chairman of the Committee on Public Health, voted in the negative. The bill then passed with the amendment and was returned to the House of Assembly where it was permitted to die.

A-408 remained in committee.

In connection with both of these bills, A-402 and A-408, which were sponsored by the State Department of Health, no advance notice of the introduction of the bills was given to our legislative committee. The Christian Scientists waged a very intense campaign among the senators for the passage of their amendment.

It should also be observed that the Christian Scientists had a certain measure of plausibility for their position, referring to the fact that the basic law—the Medical Practice Act—has exempted from its prohibitory features, since 1894, "those who minister to the sick by prayer or spiritual means".

If it is proposed, subsequently, to prohibit Christian Scientists from treating communicable diseases, it should be done, in our opinion, by an amendment to the Medical Practice Act, and the prohibition should be inclusive of the treatment of all communicable diseases.

Assembly No. 418. Permits director of State Rehabilitation Commission to appoint two vocational examiners to assist in rehabilitating tuberculous persons.

This bill became law May 24th.

Committee on Legislation.

B. S. POLLAK, M.D., Chairman
FREDERIC J. QUTGLEY, M.D.,
Executive Secretary.

* See editorial, page 345 of July Journal.

SUB-COMMITTEE ON PUBLIC HEALTH

Minutes of meeting of September 14, 1941.

Present: Dr. Nichols, Chairman, presiding; Dr. Lathrop, Dr. Jaffin, Dr. Bingham, Dr. Kessler, Dr. Raycroft, Dr. Sewall, Dr. Brown, Dr. Varney, Dr. Holters, Dr. Snegireff. Also present were Dr. Potter, Dr. Fischelis, Dr. Alexander, Dr. Wisan, Mr. McDonald, Miss Ashmun, Technical Advisers, and Dr. Salasin, Dr. Cronk and Dr. Schneider, County Society Public Health Chairmen. President Lewis and Dr. Robbins, Chairman of the Public Relations Committee, were present for a short time. The following committee goals were listed:

TRAFFIC ACCIDENTS

Dr. Sewall: The study of pathologic conditions that affect the safety of drivers on the road. It is recommended that a more careful study of eyes be made. It is felt that eyes should be examined at forty years of age and perhaps every five years thereafter.

TUBERCULOSIS

Dr. Jaffin: An attempt to establish a better understanding of the problem and purpose of the tuberculosis survey in the schools, with reference to the correct diagnosis and classification of findings. The Committee hopes to further the interest in tuberculosis surveys in industry, and will of course study any problems in connection with medical preparedness.

MATERNAL WELFARE

Dr. Bingham: A continuation of last year's program, which includes every phase of maternal welfare. Effort to have Counties hold obstetric conferences to discuss the maternal deaths in each County.

ADULT HEALTH SUPERVISION

Dr. Varney: A study of causes for rejection of draftees with recommendations for rehabilitation. The question of feeding evacuees from large cities, the establishment of hospitals for chronic illnesses, continuation of advertising of periodic health examination blanks in the *Journal*, and instruction in nutrition for high schools.

CHILD HEALTH

Dr. Brown: A study of the preparedness problem in relation to children, such as (1) the evacuation of children in New Jersey, and

(2) immunization to prevent communicable disease.

The Committee also wishes to continue its study in connection with the newborn and it is hoped pressure can be brought on the Boards of Education to make it compulsory for children to be vaccinated and immunized.

MENTAL HYGIENE

Dr. Raycroft: (1) Encourage the provision of a staff psychiatrist to work with every hospital. (2) Survey of psychiatric services in hospitals be kept up to date. (3) Continue to promote dramatic presentations of emotional problems, as seen in the general practitioner's office, before County Societies. (4) Aid community agencies in distinguishing between non-medical psychologist and medically trained psychiatrist.

CANCER CONTROL

Dr. Snegireff: The recording of cancer—in this connection a proposed bill is submitted for approval, in principle, by the Public Health Committee. (Text of bill on page 544.)

PUBLIC RELATIONS

Dr. Robbins made a plea to the Public Health Committee to provide the Public Relations Committee with a summary of its activities for use in the newspapers. The Public Relations Committee would like to have someone from each Sub-Committee serve as a reporter, to bring to its attention those items worth publicizing. This suggestion is to be discussed with the Executive Officer before any action is taken. President Lewis suggested that all Committee reports be sent to the Public Relations Committee.

MEDICAL PREPAREDNESS

President Lewis pointed out that an effort is being made to integrate all of the Advisory and Sub-Committees into the work of preparedness, particularly that phase known as civilian defense. It is hoped that each Advisory Committee will consider itself as an advisory body to the Medical Preparedness Committee. Committees are to gather data and information pertaining to national defense and hold themselves in readiness when called upon. President Lewis also indicated that through the Woman's Auxiliary Program doctors' wives, who are nurses,

will be asked to take refresher courses, so that they will be available to assist in time of emergency and disaster in their own community. It will be suggested that this be carried on in coöperation with the nursing organization and the Red Cross.

SOCIAL HYGIENE ASSOCIATION

The following letter from Dr. Blaisdell was read before the Committee, and Chairman Nichols requested that the Committee members send their written opinions to the Executive Offices on the following question: Should the New Jersey Social Hygiene Association discontinue its activities or become aligned with the New Jersey Tuberculosis League?

The meeting was adjourned at 12:15 p. m.

LEROY A. WILKES, M.D.,

Secretary to the Committee.

Following is the letter from Dr. Blaisdell:

Dear Dr. Nichols:

I spoke to you formerly about the possibility of an inclusion of the New Jersey Social Hygiene Association's activities with the New Jersey Tuberculosis League's program. Dr. Walter Clarke, Executive Director of the American Social Hygiene Association, showed the successful coöperation of these two societies in New York. A joint Committee report indicates a good possibility of their coöperation.

The New Jersey Social Hygiene Association has been weak in its financial structure and there has been some criticism of its leadership. Last year's officers resigned or failed to attend meetings and, as an expedient, a pro-tem list of officers was elected in May to see what could be done about carrying on this association's activities. The possibilities of a merger have been discussed at an executive meeting of the New Jersey Tuberculosis League. Meanwhile it was suggested, and chiefly by Dr. Pollak, that I see what, if any, would be the reaction of the Medical Society through its Public Health Committee to such an action.

Personally, I feel the New Jersey Social Hygiene Association will, and possibly should, discontinue its existence if an alignment with the N. J. T. L. is not effected. It did not appear from our discussion that the New Jersey Health and Sanitary Association has a set-up equal to carrying on its activities which are largely the distribution of literature and to provide speakers at various points in New Jersey. It has been stated that the New Jersey Tuberculosis League itself is not large enough at the moment to carry on much more work, but the American Social Hygiene agrees to supplement this from its own funds until an adjustment of the two organizations' problems can be understood and met otherwise. If unsuccessful, I feel that the League could always drop the whole matter.

Sincerely yours,

C. BYRON BLAISDELL, M.D.

SUB-COMMITTEE ON MEDICAL PRACTICE

Minutes of the meeting of the Sub-Committee on Medical Practice, held at 11:00 a. m., Sunday, September 14th, 1941, at Trenton.

Chairman Sharp presided. Present were: Drs. Sharp, Decker, Johnsen, Ulmer, Barbash, Zehnder, Ruoff, Murphy, President Lewis and Dr. Griswold, guest.

Dr. Sharp requested each Chairman of an Advisory Committee to announce the major objectives of his committee for the year 1941-42. The following reports were made:

Pharmaceutical Problems (Dr. Ulmer): Major objective has been publication of the fourth edition of the New Jersey Formulary now on the press and ready for distribution early in October.

In response to a query, Dr. Ulmer stated that the matter of proposed legislation of last year has been dropped. The Committee gave the pharmaceutical interests the reaction of the medical profession, since which nothing further has developed, and the Committee feels the pharmacists undoubtedly feel it an unwise move and have dropped it.

Contract Practice (Dr. Ruoff): This Committee functions only when a matter of grievance presents itself. However, the Committee might collect the following data: (1) List of industrial physicians in New Jersey and of draft board doctors who could handle large groups in emergency or disaster; (2) list of insurance companies, such as casualty, compen-

sation, self-assured, etc., to determine what personnel, equipment and space they could offer in disaster.

This material could be gathered and kept in the background providing it did not infringe on the duties of another body. However, if this has not been done, we have not tapped a very potent source.

Hospital Relationships (Dr. Decker): We recommend (1) continuation of dispensary survey—now being carried on at McKinley Hospital in Trenton. Funds may be forthcoming from the W. P. A. within the next few months for continuation of survey throughout the State. Since application has been made for the funds, it is thought best to await results along these lines of finances. (2) Rotating service in dispensaries for general practitioners in conjunction with Rutgers Extension Division. After three years Rutgers would grant Master of Science Degree—Rutgers would supervise and participants would write a thesis at the close of their course—to be done on a state-wide basis after a trial and error period at one institution.

Dr. Zehnder moved, seconded by Dr. Murphy, that the Chairman of the Hospital Relationships Committee write a letter instituting conversations to consider courses of rotating service in dispensaries for the general practitioners. Carried.

Dr. Decker suggested that the Chairman of

the Post-Graduate Education Committee should be designated to carry on this work; to this suggestion the Committee agreed.

Nursing and Nursing Education (Dr. Zehnder): Our 1941-42 major project will be the collection of data on physicians' wives and families as to the number of retired R.N.'s, those who have taken a course in First Aid and those who are nursing attendants.

Dr. Lewis read a basic questionnaire which would be sent out by the Woman' Auxiliary, who would collect the data and turn it over to the Nursing Committee who would have charge of the project. This data is for use in medical preparedness or in large-scale emergency and is approved by the Civilian Defense Council.

Auxiliary Medical Services (Dr. Johnsen): The Executive Officer is requested to write to the President of the Hospital Association to request appointment of a committee to work jointly with the Auxiliary Medical Services Committee of this Society; this is in accord with the approval of such a recommendation by the House of Delegates. The Committee is also considering last year's recommendation to change the name of the Committee to one more suitable to its function. We are prepared to co-operate in the medical preparedness program—determine how many portable x-ray units are

available, establish and determine what should compose mobile laboratory units.

Medical Care of the Indigent (Dr. Murphy): Major objective will be establishment of a plan for the medical care of the indigent, to be financed through the Municipal Aid Administration, and administered by the Medical Service Administration. Conferences with Mr. Mudd and Mr. Erdman are being held and it is hoped it will be obligatory for municipalities to use this plan. It may be necessary to have legislation to turn over the funds and also make it obligatory on the part of the municipalities. Payment will be based on the old E. R. A. rates.

Workmen's Compensation: In the absence of the Chairman, Dr. Harryman, Chairman Sharp called attention to the colored pages in the September *Journal* (pages 453 to 460), which indicate those portions of the law of interest and importance to physicians. Members were urged to read this article also because of its value in giving the practitioner some idea of what he should do with compensation cases.

The meeting adjourned at 12:30.

REUBEN L. SHARP, M.D.,
Chairman.

MEDICAL SERVICE ADMINISTRATION

REPORT TO WELFARE COMMITTEE, SEPTEMBER 14, 1941

Medical Service Administration opened its offices in January, and received its license to operate on March 26. During May and June, we developed the Farm Security Plan and enrolled clients under this Plan, placing it in operation as of May 1, 1941.

In June, the voluntary health plans Nos. 1 and 2 were introduced to industry. A total of 800 industrial organizations with 100 or more employees were interviewed or written to. The response from business executives and labor executives may be expressed as satisfactory. A large number answered our communications. Many of them gave us almost unlimited time for explanation and discussion of our plans, and the general problem of the medical care of employed groups. With few exceptions, these executives were sympathetic to the movement. Many recognized its need; a considerable number were enthusiastic.

ATTITUDE OF EMPLOYERS

While executive groups and executive boards approve of our plans, they hesitate to advance the introduction of the plans among their employees, for fear it will appear to the employees that compulsion is being used, and almost universally recommend that the approach be made through the labor union or welfare organization among the employed group.

There are a variety of objections among employers. Among some, the reaction is that the plans are too expensive. Others do not understand how such a complete service can be offered at such a low subscription rate. Many feel that they cannot recommend plans with income limitation provisions, which might promote class distinction and discrimination. The majority do not object to payroll deductions. A moderate number have expressed the possibility of making a contribution toward the pay-

ment of subscriptions if the demand within the employed group is sufficient.

ATTITUDE OF EMPLOYEES

When introduced to the employed person through committees of their labor unions or welfare organizations, we find these committees almost universally in favor of the plans. However, when the proposal reached the employed persons individually, we receive a different reaction. Many are not interested, feeling that they get along well with their doctor, that he will wait for the payment of his bill, or that if necessary he will demand no payment. This feeling is expressed particularly by female employees. Many expressed the belief that the same care may be obtained free by reporting to any hospital. Employed persons of this income group are not always accustomed to paying physicians promptly or completely for medical services.

Many employed persons believe that costs are too high. Others object to another payroll deduction, complaining that they now have payroll deductions for Social Security, Unemployment Compensation, Hospital Insurance, labor union dues, group life insurance, and defense bond payments.

GROUP ENROLMENTS

The most common demand of both the employer and the employee is for a combined medical and hospital policy, with one payroll deduction.

Medical service plans will not sell themselves in New Jersey. They must be sold. One organization is making arrangements with the employers for joint payment by the members, by the labor union, and by the employers. We expect ultimately to have a definite enrolment among this group. Two other groups in which preparation for enrolment is now being made gave definite promise of better results. It requires several weeks or months of preliminary negotiations between the employers, employees, or labor unions before enrolment attempts are possible. This has been the experience in other states with both medical service plans and hospital plans. It is not uncommon for negotiations to continue for several months up to two or three years before an enrolment process is complete in a large organization.

We have confidence that Medical Service Administration and its proposed plans are founded on a practical and safe basis. Our greatest need now is for an increased personnel to provide for more intimate and constant contact and follow up among our prospective groups. We need additional promotion to make us self-supporting.

COÖPERATION WITH HOSPITAL PLAN

One year ago Medical Service Administration was presented to the Hospital Service Plan of New Jersey. We realized a long time ago that if we could coöperate with them, our administrative cost would be lowered considerably. The Hospital Plan recognizes the importance of our work, and the advantage of offering medical and hospital plans payable with a single payroll deduction. Our negotiations are developing methods by which each of our two corporations may remain a distinct entity with its own governing body, but operate with joint administration where our functions are parallel. This would naturally include sales, billings, payroll deductions, and possibly a joint claim section. Such an arrangement would promote the general welfare and economy of both organizations.

Certain features of this coöperative effort require further deliberation, study, and compromise. We expect very shortly to have a definite proposal to offer to the Board of Trustees. Of course, any move we make has to go before the Trustees for approval and suggestion before we can go ahead. We still feel this is definitely to be desired, even at the cost of a little delay. If we can coöperate with the Hospital Plan we will be much better off.

FARM SECURITY PLAN

Farm Security Plan has been in operation since May 1, 1941. As of August 1, there were 1,847 beneficiaries. This is a relatively small group, living mostly in rural areas, but from a study of our experience, we hope to gain some knowledge of the approximate cost of medical care for the low-wage group. The Plan pays \$1.00 for office calls and \$2.00 for home calls, health examinations, and minor office surgery.

We have paid for a modest amount of laboratory work and x-ray work. We have paid for some obstetric cases, but have not included their cost in the quoted figures, since this service is made possible by the payment of an additional subscription.

A review of three months' work gives us the following information: (1) The average sick rate for this period was 60.5 per thousand population; (2) the cost for each case was \$3.25; (3) the number of calls per illness was 1.26 office calls and 0.69 house calls; (4) the cost per persons per month was \$0.20. These correspond with our estimates, and indicate that the cost of office and home care of the indigent without payment for supplementary services might be safely attempted at our estimated cost of \$0.19 per month per capita.

In three months we accumulated a surplus

of \$548.35. This money is held in reserve to be applied to the cost of medical care during the winter months when it is expected our sick rate will rise from 60 to about 90 per thousand population per month.

Coöperation by the profession in this experiment has been gratifying. There have been a few of what we consider legitimate objections to the acceptance of \$1.00 for office calls from men who feel that adequate medical attention cannot be given at a cost of \$1.00. However, in estimating the costs The Farm Security Administration contemplated the payment of \$1.00 to \$2.00 as the fees for calls. We cannot at this time increase the fees without jeopardizing the safety of the Plan.

INDIGENT CARE

With the coöperation, and at the suggestion of the Municipal Aid Administration, we are

studying the problem of medical care for the indigent of New Jersey. This is part of the program of the Committee on Indigent Care. We expect the Committee to make definite proposals to Municipal Aid Administration.

A flexible plan covering only the cost of office and home care is being developed. To the basic figure, other services may be added, such as cost of obstetric care, laboratory procedures, and consultation, if in the opinion of the individual municipalities these additional services are deemed desirable.

Finally, I call your attention to and urge you to read Dr. Lewis's article on page 431 of the September *Journal*, which gives a very fine summary of what Medical Service Administration is trying to do.

ELTON W. LANCE, M.D., President,
Medical Service Administration.

REPORT OF MEDICAL PREPAREDNESS COMMITTEE

SUBMITTED SEPTEMBER 14, 1941, TO WELFARE COMMITTEE

(Abstracted)

The 1941-42 organization meeting of the Committee was held July 2. Sub-committees to coöperate with the Sub-committees of the Welfare Committee on special problems expected to arise in the defense plans during the coming year were appointed as follows: Adult Health; Conservation of Vision; Crippled Children; Evacuation Problem; Nursing, Nursing Education and Training; Medico-Military Matters; Local Defense Plans; and Liaison with State Defense Council.

INDUSTRIAL HYGIENE

The study of the industrial hygiene problem has been conducted in coöperation with the Industrial Health and Hygiene Committee of this Society. This problem was referred to this Committee by the State Defense Council. At the June meeting of the Council, a motion was passed referring the problem to the Board of Trustees of this Society, requesting a resolution approving an industrial health bureau in New Jersey, and expressing an opinion as to whether such a unit should be administered by the Department of Health or the Department of Labor. The Board of Trustees recognized the importance of such a bureau in New Jersey, but was noncommittal as to whether it should be administered by the Health or Labor Department.

The present status of the problem is as follows: Upon application of the State Board of Health to the Federal Government, an industrial health and hygiene unit, paid for by Federal funds, has been allocated to New Jersey. This unit is composed of an industrial physician, an industrial engineer, and a chemist. The administrative policies regarding the State Department having final supervision of the unit has not been determined. In the meantime, under the supervision of the State Board of Health, this unit is conducting health surveys in industrial organizations having defense contracts.

The State Labor Department has introduced Bill 484, which allows for an industrial hygiene bureau within the State Labor Department, to be paid for by funds appropriated in the Bill. The Labor Department has requested that funds be allocated by the State Defense Council to aid in the support of this bureau. The Board of Health has requested an audience with Governor Edison to determine the administrative policies.

The Board of Trustees of the Medical Society has also requested an audience with Governor Edison to discuss this problem. A request for this audience has been made through the Secretary of the Governor, and has been submitted to the Secretary of State. We have received no date for an appointment as yet.

REHABILITATION

Studies of the causes for rejection and deferment have continued and monthly reports prepared for presentation to the Council.

Since the last meeting of this Committee, a rehabilitation plan to be paid for by Federal defense funds has been proposed by the National Rehabilitation Commission. The recommendation of this group is that the rehabilitation plan be operated by the Federal Security Administration, under the supervision of Federal Administrator McNutt. This problem should receive careful consideration by every State Medical Society, as a possible entree of further Federal control of the practice of medicine.

This Committee recommends strongly that a rehabilitation program for selectees on a voluntary basis be instituted in this State under the leadership of this Society, and that this be operated in coöperation with hospitals, welfare and other voluntary agencies, and private physicians; that each selectee be informed of all defects and referred to a proper welfare organization for interrogation and reference to the proper welfare organization, hospital, or private physician for medical care.

FIRST AID INSTRUCTION AND NURSING TRAINING

The Civilian Defense Plans call for an expansive program involving first aid training of civilians and the training of civilian nurses. The Committee will recommend an expansion of this part of the program through the County Societies and the sub-committees of the Wel-

fare Committee, coöperating with the American Red Cross.

COUNTY SURVEYS

County surveys of hospital and professional facilities have been completed in fifteen counties. As a very important part of the national preparedness program, these surveys must be completed.

X-RAY EXAMINATIONS

Coöperation with the Second Corps Area in the x-ray examination of selectees at Induction Stations was discontinued on July 1. A similar arrangement was resumed in October for the x-ray examination of selectees at the new Induction Station in Camden. The Committee on Tuberculosis and the Camden County Preparedness Committee coöperate in this.

RESUME OF EXAMINATIONS

A resume on June 30 reveals that over 140,000 physical examinations were performed by members of this Society. The rejection rate* for all physical and mental causes totals 29.7 per cent. The incidence of syphilis for white men is 0.54 per cent, and for colored, 13 per cent. The incidence of tuberculosis of all forms, as estimated by the Board of Health, is approximately 1.1 per cent. (In 1917-18 it was over 10 per cent.)

CHARLES H. SCHLICHTER, M.D.,
Chairman, Medical Preparedness
Committee.

* So-called rejection rates of 50 per cent or more include large numbers of deferments of registrants with remediable defects.

LOCAL GRADUATE COURSES

The following graduate courses are available to New Jersey physicians. Inquiries should be directed to the Dean, College of Medicine, 477 First Avenue, New York City. All the courses

are given in Newark, and were arranged by our Society's Committee on Post-Graduate Education with the coöperation of the Newark City Hospital.

COURSE	STARTS	ENDS	DAYS AND HOURS	INSTRUCTOR	FEE
Fractures	Feb. 11	Apr. 8	Wednesdays 9 a. m. to noon	Dr. H. A. Schulte	\$35
Amputations	Mar. 14	Apr. 25	Saturdays 9 to 11 a. m.	Dr. H. H. Kessler	\$25
Disorders of Liver and Gall Bladder..	Jan. 7	Feb. 5	Wednesdays 9 to 11 a. m.	Dr. M. Kraemer	\$20
Peripheral Vascular Diseases	Nov. 12	Dec. 12	Weds. & Fris. 3:30-5:30 p. m.	Dr. S. Z. Hawkes	\$25

A course in NEUROPHYSIOLOGY is available to New Jersey physicians through the New Jersey Neuropsychiatric Association. These lectures will be given by Dr. Paul F. Hofer on Wednesday evenings at 8:30 p. m., beginning October 22. The demonstrations will be held in Newark. Tuition fee is \$25.00. Inquiries and applications should be directed to Dr. Charles Englander, 41 Hillside Avenue, Newark.

**FOURTH ANNUAL
FALL CLINICAL CONFERENCE
of
THE MEDICAL SOCIETY OF NEW JERSEY**

Wednesday, December 3

Doctors' Day in Elizabeth

PRELIMINARY PROGRAM

(A detailed program will be published in the November *Journal*)

THEME: Industrial Medicine and Civilian Defense

HOST: The Union County Medical Society.

PLACE: Elizabeth, N. J.

DATE: Wednesday, December 3, 1941.

Morning

Clinical presentations at the Elizabeth General Hospital, St. Elizabeth's Hospital, and the Alexian Brothers' Hospital, of Elizabeth, N. J.

Luncheon

Visits to large industrial plants in the Union County area with inspection of medical departments.

Afternoon

Scientific papers under auspices of the Scientific Sections of The Medical Society of New Jersey.

Evening

Banquet; address by Johannes Steel, nationally known radio commentator.

Mark it in your diary now: December 3 is Doctor's Day in Elizabeth.

ACADEMY OF MEDICINE

HOUSEWARMING

New Jersey doctors are cordially invited to the "Housewarming" meeting of the Academy of Medicine of Northern New Jersey, on Thursday evening, October 16. The short business session will start at 8:45 p. m., to be followed immediately by the formal opening of the Eagleton Medical Civic House. The first speaker will be Dr. Wells P. Eagleton, whose greetings will be followed by a response by the Academy's first President, Dr. Edward J. Ill, Senior Fellow of The Medical Society of New Jersey.

The principal address of the evening will then be delivered by Dr. Howard W. Haggard, Professor of Applied Physiology at Yale University. This will be followed by a formal inspection of the new building and a collation at which the Woman's Auxiliary to the Essex County Medical Society will act as hostesses.

MEDICAL AND SURGICAL MOVING PICTURES

The Committee on Public Health and Medical Education of the Academy announce a reg-

ular moving-picture session, the fourth Friday of each month, at 4:30 p. m., at which significant pictures of medical or surgical procedures will be presented.

The first such session will be on October 24, at which the Miles operation and the combined abdomino-perineal resection for carcinoma of the rectum will be presented. All physicians are invited to attend.

SECTION MEETINGS

The "Fenestra-Nov-Ovalis" operation will be discussed by Dr. Julius Lempert of New York on Monday, October 13, and the "Relation of Infections to the Rheumatic State" will be reviewed on Tuesday, October 14, by Dr. A. F. Coburn, Assistant Professor of Medicine at the College of Physicians and Surgeons. These section meetings open at 8:45 p. m.

Note: All of the above meetings are held at the Academy of Medicine, 91 Lincoln Park, Newark, N. J.

SUPPLEMENTARY LIST OF MEMBERS NO. 6

TO THE OFFICIAL LIST OF MEMBERS, MARCH 15, 1941

The figures in parentheses refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14), Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

ACTIVE MEMBERS

Bierach, Jules, Water st., Toms River (15)
Byrnes, Elizabeth, 715 N. Charles st., Baltimore, Md. (7)
Caprio, Orlando G., 105 Third av., Newark (7)
Donnelly, John H., 45 Marion av., Newark (7)

Jackson, Elmer C., 98 Washington st., E. Orange (7)
Just, Francis, 564 High st., Newark (7)

ASSOCIATE MEMBERS

Feliciano, Vincent, 33 N. 8th st., Hawthorne (16)
Schwarz, Julianna, 255 Harrison st., Passaic (16)

THE DOCTOR IN THE NAVY

For every two thousand officers and men in the navy and marine corps the authorized allowance of medical officers is thirteen. The present great expansion of the navy therefore has produced greatly increased need for doctors. Many young physicians have joined the regular navy and the Naval Reserve and many of the older doctors with specialist qualifications have joined the specialist group of the reserve. There are still a number of vacancies both in the regular navy and the Reserve.

To qualify for the regular navy, doctors must be under 32 years of age and must have completed at least one year of internship.

For the medical corps of the Reserve, doctors up to 50 years of age may apply. If under 35, they are eligible for the general service group. Between 35 and 50 they are eligible only for the specialist group. The specialist group is organized into hospital units composed of eight different specialists and one dentist. It is not the Navy Department's intention to call these groups to active duty except in case of general mobilization.

The rank offered to doctors varies with age, experience and professional repute. Those entering the regular navy and the general service group of the reserve are commissioned as lieutenant (junior grade) with salary of \$2699 or \$3158 per year, depending upon whether they have dependents. In the specialist group the rank is either lieutenant (junior grade), lieutenant, or lieutenant commander, and the salary ranges from \$2699 to \$4848.

The physical requirements of the navy are rigid, even in the matter of height, weight, vision, hearing and teeth. This is because, if an individual becomes physically disabled or if an existing disability is aggravated while on active duty, he is eligible for a liberal pension or retirement pay.

Medical officers in the hospital specialists units, when called to active duty, will be as-

signed to naval hospitals in the United States, to hospitals beyond the continental limits of the United States, or to hospital or ambulance ships, and will be used in their specialty.

For medical officers in the general service group and in the regular navy, active duty offers a wide variety of experience in many parts of the world and training in many specialties. They may be assigned to battleships, cruisers, aircraft carriers, destroyers, or hospital ships. They may be detailed for duty at naval hospitals, navy yards, naval training stations, submarine bases, naval air stations, or marine corps bases in the United States or beyond the seas. They may spend most of their period of active duty at the Naval Hospital in Brooklyn or Philadelphia, or they may serve with the marines in Iceland, Bermuda, Hawaii, or the Philippines. They may be detailed to the Naval Air Station at Pensacola, Florida, or to the Submarine Base in Alaska. They will have some choice as to where they go and what they do, for the navy permits officers to ask for duty they prefer and assigns them to it if practicable to do so.

Junior medical officers of the regular navy and, to a lesser extent, medical officers of the general service group of the reserve, have opportunities for special training both in naval and civilian institutions. Besides training in the usual professional specialties, medical officers are trained in aviation medicine, industrial medicine, chemical warfare, and in the research problems of diving and submarine warfare.

Doctors who live in Northern New Jersey and desire information concerning the Medical Corps of the Navy or Naval Reserve may obtain it from Capt. E. C. White M.C., District Medical Officer, Headquarters, Third Naval District, 90 Church Street, New York, N. Y. Those who live in Southern New Jersey should write to Capt. John B. Kaufman, M.C., Fourth Naval District, Philadelphia, Pa.

DECEASED PHYSICIANS — NEW JERSEY

Name	Age	Date of Death	Place of Death	Residence	Cause of Death
Walter I. Budington	56	July 4, 1941	Newark	Same	Bullet wound.
Walter E. Deuel	61	July 18, 1941	Deepwater	Carneys Point	Coronary sclerosis.
William H. Haines	55	July 5, 1941	Audubon	Same	Organic heart disease.
Harry S. Kieser	37	July 11, 1941	Somers Point	Reading, Pa.	Cerebral hemorrhage.
Howard Miller	83	July 3, 1941	Paterson	Ridgewood	Carcinoma of prostate.
George A. Ragoff	51	July 31, 1941	Newark	Same	Pyloric obstruction.
Jacob C. Shinn	79	July 24, 1941	Bridgeton	Fairton	Carcinoma of pancreas
William G. Telfair	83	July 14, 1941	Orange	Same	Carcinoma of colon.
Alexander J. Verdon	34	July 19, 1941	Hoboken	Ridgefield	Peritonitis.
William C. Wescott	72	July 26, 1941	Atlantic City	Same	Coronary thrombosis

OBITUARIES

DR. WARREN H. FAIRBANKS

Dr. Warren H. Fairbanks, former President of the Monmouth County Medical Society and Medical Director of the Allenwood Sanatorium, died suddenly August 5th at his home, 27 Broadway, Freehold, N. J.

At the time of his death he was attending physician at the Farmingdale Preventorium and a member of the staff of Fitkin Memorial Hospital, Neptune. Dr. Fairbanks was born in Vermont. After receiving his early education at Vermont and Boston University, he entered the Methodist ministry and for four years was pastor of the Springfield Avenue Church, Philadelphia.

He left the ministry in 1912 and entered the New York Homeopathic Medical College in Westbury, graduating in 1916. He served his internship in Ann May Memorial Hospital, Spring Lake, and started practice in Freehold, N. J., in 1917. He became Medical Director at Allenwood Sanatorium in 1923, after having been graduated from Trudeau School of Tuberculosis, Saranac Lake, New York. He worked at the Colorado Spring School for the Study of Chest Diseases in 1926.

During the first World War he was a member of the Medical Division of the Monmouth County Draft Board. He was President of Monmouth County Medical Society during 1935.

DR. WILLIAM T. CALLERY

Dr. William T. Callery died August 11, 1941, at his home in Weehawken. Death was caused by sinus infection from which he had been suffering since last Spring. Dr. Callery was born in Weehawken in 1889. He received his medical degree from Fordham University in 1913. He served in the World War with the 309th Ambulance Company of the 78th Division, which he helped form.

Dr. Callery was an ear, nose and throat specialist on the Staff of St. Mary's Hospital, Hoboken, and the County Hospital at Laurel Hill.

DR. STEPHEN GERARD LEE

Dr. Stephen Gerard Lee, 66, East Orange practitioner since the turn of the century, died of an apoplectic seizure on September 9, 1941. Dr. Lee was born in Brooklyn and was graduated from the Bellevue Medical College in 1898. He interned the following year at the Orange Memorial Hospital, and since that time has been a member of its staff.

At one time he and his son, Dr. Stephen Gerard Lee, Jr., held the State father-and-son golf title.

He was well known in golfing and Masonic circles.

DR. JAMES MICHAEL HANRAHAN

Dr. James Michael Hanrahan, a prominent Union County obstetrician, died of a stroke at the age of 57 on September 1, 1941. Dr. Hanrahan was stricken while making a call on a patient in Roselle Park. He was born in Connecticut in 1883, and was graduated from the College of Physicians and Surgeons in Baltimore in 1910. He interned at St. Barnabas Hospital in Newark, and St. Elizabeth and Alexian Brothers Hospitals in Elizabeth.

He was an active member of the Knights of Columbus and of the Elizabeth Lodge of the Elks, as well as the Union County Medical Society. He was Chairman of the Nurses' Training School Committee of the St. Elizabeth Hospital, and Chief of the Clinics and Consultant in Surgery at Alexian Brothers Hospital.

Dr. Hanrahan was a Director of the North Elizabeth Building and Loan Association and an active Trustee of the Immaculate Conception Church.

He was an amateur boxer and an ardent baseball fan.

DR. MORRIS FELLMAN

Dr. Morris Fellman of Weehawken died July 14, 1941, at Baker Memorial Hospital, Boston, Mass. Death was caused by malignancy. Dr. Fellman was born in Syracuse in 1897 and was graduated from Syracuse Medical College in 1925, serving his internship at Bellevue Hospital, New York City, and the Jersey City Medical Center.

He was Attending Surgeon and Chief of the Thyroid Division at the Jersey City Medical Center for the past 15 years, and was a Consulting Surgeon at Margaret Hague Maternity Hospital. He was a Fellow of the American College of Surgeons.

DR. JOHN M. CASSIDY

Dr. John M. Cassidy of Jersey City died on August 22, 1941, while at the home of a patient. Death was caused by syncope due to cardiac disease. Dr. Cassidy was born in Scotland in 1886. He received his medical degree from the New York University College of Medicine in 1912. He was a heart specialist and was on the Staff of the Greenville Hospital for a number of years.

Dr. Cassidy was a former President of the Hudson County Medical Society. He was a member of Phi Beta Kappa, and had been a Professor at the Medical College of Bellevue Hospital.

THE IMPROVEMENT OF SCHOOL MEDICAL SERVICE

II.

Second of a series of three articles prepared by the Committee on School Health of the American Academy of Pediatrics

This Committee emphasizes that total and complete supervision for all children is beyond the possibility of attainment through any plan yet devised for medical service in the public schools. This statement is in no sense a defeatist policy. It is negative only in emphasizing the public school's incapability of providing the mechanism for achieving this ideal. When the schools attempt to take over so large a service they lose their effectiveness as an educational force working towards an ideal. They become wholesale dispensers of service; but thorough-going medical health supervision is not a commodity that lends itself to free distribution. It is an ideal to be achieved; and for such achievement we look to education. When the school medical service allows the school authorities and public to believe they are providing real health supervision by offering a rapid medical inspection of each child in school every year, then they nullify every educational effort toward the ideal of optimal health service. They block progress toward the development of the best possible form of health supervision in the community. In many places the gesture of hasty medical judgment, if not actual march-by inspections, has become so firmly entrenched with special records, form notices to parents, and follow-up procedures based on dubious or inadequate medical opinion, that we find an appearance of service without honest achievement. We have organized machinery that pretends health supervision. In fact, the administrative machinery may actually interfere with children receiving the health supervision which we desire. Parents who believe the school gives annual health examinations are not likely to seek the health supervision that they might obtain from a private physician.

Because school medical examinations began with an emphasis upon the discovery of the more obvious physical handicaps of children, and without the responsibility for diagnosis and treatment, many have assumed that the *discovery of physical defects* was the main function of the physician in the schools. Because the more obvious physical handicaps could be recognized with a reasonable accuracy, it was assumed that the physician could discover all the needs of the children by the simple expedient of recording every deviation from a *supposed* normal. When the nurse carried out follow-up

only on the more obvious or serious physical handicaps, the program worked quite satisfactorily. But a false thoroughness in the examination was attempted; there was waste motion and loss of confidence on the part of practicing physicians and parents.

Actually, parents want to know *how* serious are the findings of the school examination. They expect the physician, or the nurse in school to tell them *why* they should seek medical care. They do not know the school service is a limited one. In fact, in some places the school or health authorities may unconsciously misrepresent the service, and promise more than can be delivered. This does not occur when the limitation of the school examination, or the signs and symptoms recognized by the school physician, are properly interpreted to the parent.

EDUCATION NECESSARY FOR PROGRESS

The five principles proposed by the American Academy of Pediatrics for the improvement of school medical service have been considered from the standpoint of a development of school health services that will progress forward toward the best possible health supervision for all children. Such a development must provide for very much more education of parents and children regarding medical service and health supervision; and this is very definitely the function of the school. We recommend the educational goal of continuous personal health supervision and not merely a series of examinations of the well child, nor a periodic search for defects with a complete separation of the advice to the sick and the well.

We recommend education for attitudes that will create a demand for the best possible health supervision—not merely wholesale examinations performed in a mechanical way without regard for that medical advice and guidance necessary for obtaining the best modern medical service. Just as education should aim for the highest cultural and ethical training even though all may not be able to take advantage of the best that our educational institutions afford, so health education should aim at creating a demand for the best possible health supervision that modern medicine can offer.

ROUTINE EXAMINATIONS

Although the medical examinations of school children are now generally accepted as a fundamental part of the school health program there is all too often a failure to achieve their purpose. It may be noted that there is a marked dissatisfaction with the quality of medical service, or a lack of use of the physician in the schools as a medical adviser, or an unfounded defense of the regimentation of children to get them "through the mill" of so many examinations per hour, per week, or year.

Where such unsatisfactory forms of school medical service prevail there is usually such a preoccupation with routine examination and records of defects that the physician must work under pressure. He must examine all the

pupils. He faces a limitation of the time spent on each pupil. This limitation interferes with his best medical judgment. He has not time to advise regarding the child's needs in his school environment. He cannot take time to explain to the nurse or the parent the possibilities of medical service that might benefit the child, nor to interpret the signs and symptoms so as to lend conviction to his recommendations and guidance in the use of medical facilities. An over-emphasis, then, upon the routine examinations interferes with medial standards. It interferes with education for proper attitudes about medical service, and with actual advice and guidance which is essential to avoid medical neglect.

Note: Readers are invited to submit to the Journal their comments on this report.

TENTATIVE CANCER LEGISLATION

SUBMITTED BY THE COMMITTEE ON CANCER CONTROL

AN ACT to promote the prevention and cure of cancer; to make cancer and other malignant tumors reportable to the State Department of Health; to provide State aid to cancer clinics for statistical research purposes; to enable the State Department of Health to conduct an educational campaign for cancer control; to carry on statistical research; and to make annual appropriation to the State Department of Health to carry out the provisions of this Act.

Be it enacted by the Senate and General Assembly of the State of New Jersey:

REPORTING OF CANCER AND OTHER MALIGNANT TUMORS

1. Every physician shall immediately give notice to the State Director of Health of every case of cancer and other malignant tumor under his care.

2. Such notice shall contain such information concerning the case as shall be required by the State Director of Health and shall be in the form of a written confidential report on a *special cancer report form*, to be distributed by the State Director of Health.

3. Whenever an examination of a tissue specimen in a laboratory discloses the existence of cancer or other malignant tumor, the person making such examination shall immediately report the same, together with all the facts in connection therewith that may be required by the State Director of Health.

4. Like notice shall be given by the person in charge of any hospital, clinic, dispensary, asylum, nursing home or other similar public or private institution of every case of cancer, malignant tumor, or malignant disease of the blood and lymphatic systems.

5. In the case of patients treated in hospitals or institutions, a single report shall be regarded as adequate.

6. The reports of cases made pursuant to the provisions of sections one to five inclusive, shall not be divulged or made public so as to disclose the identity of any person to whom they relate, by any person, except insofar as may be authorized by the State Director of Health.

Nothing in the above sections shall be construed to compel any individual to submit to medical or health department supervision or inspection.

PROVISION FOR STATISTICAL RESEARCH AND INVESTIGATION OF FACILITIES FOR DIAGNOSIS AND TREATMENT OF CANCER, ETC.

7. The State Director of Health shall conduct statistical research, investigations of the cause, mortality rate, methods of treatment, prevention and cure of cancer and allied diseases, including the nature and extent of the facilities available in this State, for the diagnosis and treatment of these diseases and shall cooperate with local health authorities, medical and allied professions, hospitals, clinics, voluntary associations and other State and private agencies in the betterment of existing facilities for the diagnosis, treatment and control of cancer.

CONDUCT OF EDUCATIONAL CAMPAIGN AND PROVISIONS OF STATE AID TO CANCER CLINICS FOR STATISTICAL RESEARCH PURPOSES.

8. The State Director of Health shall conduct an educational campaign for cancer control and shall formulate and put into effect a system of state aid to New Jersey cancer clinics requiring such aid for statistical research purposes only.

APPROPRIATION OF FUNDS

9. The sum of fifteen thousand (\$15,000.00) dollars is hereby appropriated to the State Department of Health to carry out the provisions of this Act.

COUNTY SOCIETY REPORTS

ATLANTIC COUNTY

Sloan G. Stewart, M.D., Reporter

The first fall meeting of the society was held at its new meeting place in the Hotel Traymore, September 12, 1941. Dr. Harry Subin presided, and introduced Dr. Elias J. Marsh, President-Elect of the State Society of New Jersey. He spoke of the medical service plan adopted by the society and asked for its support. He also urged physicians to support the *State Journal* and its new editor, and to contribute more freely in original work.

The guest speaker was Dr. I. S. Ravdin, professor of surgery at the University of Pennsylvania School of Medicine and a member of the National Research Council. Special reference was made to military surgery and the relationship between the Army and Navy in government emergencies and the National Research Council. Dr. Ravdin then gave a very instructive presentation of some of the more important advances in surgery and emphasized that they were due more to a better understanding of the physiology and chemistry of disease than to mechanical advances in technique. Problems of nutrition and wound healing were considered in relation to hypoproteinemia and vitamin C deficiencies. The present lack of knowledge of the mechanism of surgical shock was emphasized and an outline given of a program for studying shock in the future. The treatment of burns, the use of heparin in surgery and the present status of sulfonamid derivatives were briefly presented.

This excellent talk was discussed by Drs. Silvers and Allman, members of the surgical staff of the Atlantic City Hospital.

A very brief business meeting concluded the evening. The society approved the publication of the Health Section of the Atlantic City Press during the A.M.A. convention in Atlantic City next June, instead of during the State Society convention in 1942.

BURLINGTON COUNTY

T. Bruce Dickson, M.D., Reporter

The second annual joint meeting of the *Burlington County Bar Association* and the *Burlington County Medical Society* was held on September 11, 1941, at the Medford Lake Lodge, Medford, N. J. The first of these meetings, which took place last year, was the first of its kind to be held in this county. These two meetings have been so successful that it is to be a yearly event in the future.

Preceding the joint meeting, each group held its own business discussion.

At the medical meeting Dr. Parry Scott, President-Elect, presided in place of Dr. Dean LeFavor, President, who was unable to be present. Several business matters were discussed but were tabled for further action at the next meeting. Guests who were present were Dr. Paul Mecray, Jr., of Camden County and Drs. Diverty, Nelson and Wood of Gloucester County.

The first action taken by the joint meeting, at which the wives of the members of both organizations were present, was the eating of dinner.

Dr. Parry Scott made a short welcoming speech to the Bar Association for the Medical Society. Mr. Richard B. Eckman, the secretary and treasurer of the Bar Association, did the same for the Bar Association. Mr. Eckman, for Mr. Ralph W. E. Haines, the president of the County Bar Association, who was ill.

Mr. Eckman introduced the guest speaker, Mr. George J. Thompson, who is professor of law at Cornell University. Mr. Thompson's talk was entitled "An Oriental Odyssey", which was a recital of glimpses of Old China from 1914 to 1917 when he was professor of Anglo-American law at the University in Tiensten. He told of some of his personal experiences, many of which were amusing. The period 1914 to 1917 was just after the revolution, and the new China Republic was beginning. With this period in mind, he emphasized the terrible effect of an over-centralized government in one city. He also warned against a politico-economic system of government. Both forms of which are in force in some of the countries of the world today, with disastrous results.

Among the guests at the joint meeting were Colonel Theodore O'Brian, acting Post-Surgeon of Fort Dix and, Assemblyman A. Matlack Stackhouse of Burlington County.

During the dinner the Adelphia quartet sang popular and favorite old songs, which made quite a hit.

GLOUCESTER COUNTY

C. A. Bowersox, M.D., Reporter

The *Gloucester County Medical Society* held its first meeting of the season at the Woodbury Country Club on Thursday, September 18, 1941. The meeting was called to order by the newly elected President, Dr. Frederick Wandall.

Dr. Collins reported that the State Public Relations Committee had designated the week of October 5th for talks to the Kiwanis Clubs of the State. In each club a doctor has been assigned to give a talk on some aspect of "The American Way in Medicine".

The President appointed Dr. Joseph Hughes as Chairman of the Medical Advisory Board. Additional members of the committee are Dr. Fred J. Faux and Dr. Clarence A. Bowersox.

Mr. J. Lenox Gray told of the advantages of the Hospital Service Plan of New Jersey as it relates to the doctors of the Society as a group. He urged them to join the plan and explained that enrollment must be a group and not by individuals.

Speaker of the evening was Dr. Henry B. Decker, who gave an interesting talk on "The Diagnosis and Treatment of Some of the Commoner Dermatoses". He listed four functions of the skin: (1) protection; (2) heat regulation; (3) tactile sense; (4) respiratory. Dr. Decker stated that sulfathia-

zole in a lotion form is being used extensively to control pyogenic complications of skin disease. The drug is also given by mouth, the condition improving in 24 to 48 hours. Treatment of poison ivy is difficult at times as there are many means of getting in contact with the pollen. Dr. Decker has been disappointed in efforts to desensitize the individual to the poison ivy. He has found that it might even increase the sensitivity of the individual. Soap and water should be used freely after contact has been known. With vesicles present, isotonic or even hypertonic solutions should be used—for example, boric acid, calimine, ferric chloride 5 per cent and sodium hyposulphite 5 per cent are used.

Allergy usually begins in infancy and is due to milk protein. If it is due to lact-albumin or globulin it is corrected by boiling the milk. If due to casein, a soy bean diet must be given. If it is not corrected promptly, the child will soon become allergic to many more agents.

Sulphur is now frequently used to control staphylococcal infections of the skin and ammoniated mercury is used in streptococcal infections. Two per cent sodium benzoate solution controls fungi and yeast infections. Psoriasis is now believed to be a deficiency disease as it is definitely improved in the summer due to the sunlight. It does not occur anywhere in the tropics. In some cases gastrointestinal disturbances might be suspected and the patient is then placed on a low fat diet.

HUDSON COUNTY

John N. Connell, M.D., Reporter

Regular meeting of the *Hudson County Medical Society* was held Tuesday, May 6, 1941, at the Masonic Club, Jersey City. Meeting was called to order by the President, Dr. George Ginsberg, at 9:40 p. m. Minutes of the last regular meeting and executive committee meeting were approved as printed in the Bulletin.

Report of Publicity Committee: "For the past year, your Publicity Committee has carried on as usual, supplying speakers for lodges, Parent-Teacher associations, churches, etc. They have parted with some very instructive and valuable information which has benefited the public greatly.

"During our Seventh Anniversary Radio Program we were privileged to present our President, Dr. George Ginsberg, to our radio public along with the Hon. John F. O'Neil and Dr. John J. Mackin in a very interesting half-hour of broadcast reviewing what we have done and expect to do for the public health.

"Your Committee thanks all those members who gave so unselfishly of their time and knowledge to better the health index of our community and to the personnel of Station WAAT for their help and patience and to Mr. Harry F. Downes for his great help."

(Signed) W. JAY SNYDER, M.D., Chairman,
Publicity Committee.

Report of Publication Committee: "Your Publication Committee has endeavored to give you a bigger and better Bulletin during the past year, and we are looking forward to making the Bulletin a self-paying enterprise through additional advertise-

ments and by making its contents more entertaining.

"We are always looking for criticism, especially of the constructive sort, and would appreciate any comments from our members that will better our publication."

(Signed) W. JAY SNYDER, M.D., Chairman,
Publication Committee.

Report of Public Health Committee: "The Committee has been very active and several meetings have been held this year. At the December meeting, the uniform application of immunization for diphtheria was discussed. The three-dose method was approved as the standard used by the New York Board of Health and the Jersey City Board of Health.

"The last meeting of the Committee was a joint Public Health Committee meeting with representatives of the Hudson County Medical Society and the Council of Social Agencies.

"This meeting was called to discuss convalescent care. The question arose as to whether the Convalescent Care Committee, as appointed by the Council of Social Agencies, should continue on its own to conduct this survey, with the express support of the Hudson County Medical Society and the Medical Directors of the various hospitals, or whether it would be better to form a new committee with this committee as a nucleus.

"It was regularly moved and seconded that the survey be enlarged to take in the entire county.

"Dr. McNeeney recommended that our hospitals donate hospital beds to take care of indigent cases as an experiment.

"Dr. O'Hanlon felt that there possibly would be 100 beds available for this purpose at the Jersey City Medical Center, provided that in the near future the Army and Navy do not request these beds.

"The Committee felt that further discussion should be deferred until the Fall of the year."

(Signed) CLAUDIO E. MCNEENEY, M.D.,
Chairman, Public Health Committee.

Report of Medical Preparedness Committee: "Your Committee has held several meetings during the past year and the Chairman has attended sessions of the State Preparedness Committee. Complete files of all correspondence with the State Committee have been maintained.

"With reference to the medical personnel of the Boards, your Committee has cooperated with the State Committee.

"The number of men required for this work has greatly exceeded the number originally contemplated and for that reason certain of the standards originally set up by the American Medical Association, especially as to the age of the men appointed by the civil authorities to participate in this work, have not been followed.

"The record of practitioners completing and forwarding the questionnaires sent out by the American Medical Association many months ago is still very incomplete and is a source of much concern to the national and state medical authorities. Your Committee is now endeavoring, at the suggestion of the State Committee, to arrange a system of collabora-

tion with the Hudson County Medical Society Auxiliary to aid and clean up this mess. The interest of all individual members of our Society who have not submitted this questionnaire is urgently invited to the necessity of doing so.

"The matter of organization for civil defense has occupied the attention of this committee throughout the past year.

"Certain data have been obtained from the hospitals with reference to their emergency capacity, but your Committee has not felt it wise to undertake as elaborate a set-up for this purpose as some other counties have adopted on paper. Your Committee feels, at this time, that in as much as the program for civil preparedness under the direction of the Governor is being organized by municipalities, it would be unfortunate and unwise for this Committee to undertake to organize it on a county-wide basis.

"Your Committee recommends that in order to avoid duplication of effort with these preparedness efforts operated by the civil authorities and the efforts of the American Red Cross whose work is also organized on the municipal basis, that this Society do not proceed further with attempts to organize a program on a county-wide basis but seek rather to have its several members, as opportunity offers, identify themselves with the organization set up by the municipal authorities."

(Signed) S. A. COSGROVE, M.D., Chairman,
Hudson County Medical Preparedness
Committee.

PROPOSAL OF NEW MEMBERS

Dr. Charles John Aria, 574 Bergen Ave., Jersey City
Dr. George L. Bellina, 518 79th St., North Bergen
Dr. Robert A. Cosgrove, 254 Union St., Jersey City
Dr. William V. Harz, 817 Ave. C, Bayonne

Regularly moved and seconded they be referred to the Board of Censors.

ELECTION OF NEW MEMBERS

Dr. Michael Conti, 280 Fourth St., Jersey City
Dr. Angelo R. Gianni, 117 Hancock Ave., Jersey City
Dr. Charles E. Rosen, 1513 Palisade Ave., Union City

Regularly moved and seconded the Secretary cast one ballot.

SCIENTIFIC SESSION

Symposium on Anesthesia—

Dr. Alex. Povalski, "The Present Status of General Anesthesia".

Dr. John J. O'Shea, "The Present Status of Spinal Anesthesia".

Dr. John J. Muccia, "Obstetric Anesthesia and Asphyxia Neonatorum".

Dr. Abram P. Blakey, "Pre- and Post-Operative Anesthetic Care".

Dr. William J. Gleeson, "Medical Points of Interest in the Choice of Anesthetic Care."

Discussors: Drs. C. J. Kelley, L. Lange, T. J. Schuck.

RESIGNATION

Dr. G. Ginsberg read the following letter from Dr. J. F. Londrigan:

"I hereby tender my resignation as a delegate to the Nominating Committee of the State Medical Society.

"Permit me to take this opportunity of expressing to you, and to the members of the Hudson County Medical Society, my sincere thanks and appreciation for the many favors conferred upon me."

(Signed) JOSEPH F. LONDRIGAN, M.D.

Dr. T. J. Schuck asked if a nomination was in order. When he was assured that there was, Dr. Schuck nominated Dr. James F. Norton as a Delegate to the Nominating Committee of The Medical Society of New Jersey.

Seconded by Dr. L. F. Donohoe.

Dr. Conty moved the nominations be closed. Seconded.

REPORT OF ELECTION COMMITTEE

Dr. W. M. Doody, Chairman of the Election Committee: "In view of the fact that there is no opposition, I move that the Secretary be instructed to cast one ballot for the election of officers. Seconded.

President: A. J. Conty

Vice-President: W. A. Pinkerton

Treasurer: H. Spence

Secretary: T. McG. Brennock

Reporter: J. N. Connell

Board of Trustees, 3 years to 1944: W. L. Williamson, E. J. Chapman

Board of Censors, 3 years to 1944: J. L. Evans

Audit Committee, 3 years to 1944: R. Good

Publication Committee, 3 years to 1944: H. B. Ainsley, J. C. Talty, N. L. Shulman, V. J. Sheeran

Delegate to State Nominating Committee, to serve in 1942: J. F. Norton

Alternate to State Nominating Committee, to serve in 1942: J. L. Evans

Committee on Constitution and By-Laws, 3 years to 1944, S. Kooperstein

Legislative Committee, 3 years to 1944: H. Spence, S. G. Scott, E. J. Connell

Election Committee, to serve in 1942: S. G. Scott, D. D. Dougherty, J. J. Danielson, L. A. Schneider, W. M. Doody, M. Shapiro, S. S. Schept

Maternal Welfare Committee, 3 years to 1944: J. J. McCarthy, E. G. Waters, A. O. Largay

Delegates to State Convention, 3 years to 1944: T. McG. Brennock, V. P. Butler, A. W. Littler, S. R. Woodruff, H. Spence, J. A. Botti, W. T. Callery, E. J. Daly, A. J. Conty, A. J. Walscheid, M. Shapiro

Alternates to State Convention, 3 years to 1944: H. L. Taft, A. Weiss, D. D. Dougherty, R. J. Doran, E. M. Kiely, F. Pearlstein, B. P. Potter, W. T. Fifer, G. C. Lawsing, J. L. Hollywood

Nominating Committee, to serve in 1942: J. L. Evans, E. J. Daly, W. T. Callery, J. A. Botti, C. J. Larkey

NEW BUSINESS

Dr. W. M. Doody: "I wish the delegation to be instructed to take action on the resolution which I am about to present:

"Whereas, The New Jersey State Department of Public Instruction is reported to be considering establishing a standard of qualifications for psychi-

atrists and psychologists who may be appointed to positions in the Public School System throughout the State; and

"Whereas, The Director of the Bureau of Teachers' Qualifications, which would handle these matters, has been reported to have taken the stand that, 'It is doubtful that there would be any distinction between the general requirements for psychiatrists and psychologists, if the psychologist is equipped to perform the duties and responsibilities of a psychiatrist'; and

"Whereas, It is reported that a committee of school psychologists are working on this matter; and

"Whereas, The public is already confused regarding the distinction between these two professions; and

"Whereas, Such action by the State Department of Public Instruction would increase this confusion and would further open up the opportunities of unqualified persons to perform the functions of a psychiatrist and practice psychiatry; and

"Whereas, The basic distinction between a psychiatrist and psychologist, which is not generally understood, is that a psychiatrist must be a Doctor of Medicine duly licensed to practice medicine in the State and that the removal of this distinction by the State Department of Public Instruction would not be in accord with the facts in the law; therefore

"Be It Resolved, That The Medical Society of New Jersey believes that it is imperative that a distinction be made between the qualifications of a psychologist and the qualifications of a psychiatrist and that it further believes that the minimum qualifications of a psychiatrist for employment in the Public School System should not be less than now required by statute to qualify for the certification for the admission of a person to an institution in this State established for the care of the insane, epileptic and feeble-minded; and

"Be It Further Resolved, That this Society take all proper steps to protest to the Department of Public Instruction of this State against any action by them that would not retain the proper distinction between these two groups; and

"Be It Further Resolved, That the Officers of The Medical Society of New Jersey and the proper committees thereof be instructed to take such actions as may be necessary to bring the views of this Society to the attention of the State Department of Public Instruction, and such other agencies as may be deemed necessary."

Dr. J. F. Londrigan moved the adoption of this resolution. Seconded by *Dr. J. L. Evans*.

Dr. G. Ginsberg: "I personally wish to thank the members of the Society. It has been an elevating experience to serve as President of the Hudson County Medical Society for the past year and I have enjoyed it very much. I now name *Dr. Evans* and *Dr. Norton* to escort the new President, *Dr. A. J. Conty*, to the chair."

Dr. A. J. Conty: "I am very grateful and deeply appreciative to be your presiding officer for the

coming year and I feel sure that with your coöperation and assistance we will have a very profitable and happy year. As in the past, things that pertained to Post-Graduate, Maternal Welfare, Public Health, etc., will receive our coöperation and support. We will try to better the position of the physician. I am sure that I voice the sentiments of all the members in congratulating my predecessor, *Dr. George Ginsberg*, for his very able and faithful service during the past year."

Meeting adjourned 12:00 midnight.

MORRIS COUNTY

Wilbur M. Judd, M.D., Reporter

The Spring Brook Country Club, Morristown, was the scene of the Annual Dinner Meeting of the *Morris County Medical Society*, Thursday, June 19, 1941, which was well attended and honored by many guests from neighboring societies, including Third Vice-President *Dr. Londrigan* and *Dr. Wilkes*, Executive Secretary of The Medical Society of New Jersey.

The afternoon was devoted to golf, the results of which showed some were good golfers and others merely good physicians.

Prior to the dinner, which took place at 7 p.m., some efforts were made to combat the dehydration due to the exertion and heat.

Following the dinner, *Dr. Gibb* presided at the business meeting, at which the following officers were elected for the year 1941-1942:

President: D. W. Teller
Vice-President: F. C. Bowers
Secretary: G. J. Young
Treasurer: J. H. Harrington
Reporter: W. M. Judd

Executive Committees Officers Ex-officio; Councilor Members: W. B. Gibb, D. J. Geary, S. Teskey.

Delegates to State Convention (term expiring in 1944): J. S. Forbes, S. Teskey.

Alternate Delegates to State Convention: E. McElroy, E. T. Carberry, R. A. Eckhardt, J. L. Voss, A. O. Hubert, W. M. Judd, C. A. Musetto.

State Nominating Committee: B. C. McMahon.
Alternate: B. G. Sherman.

Dr. McMahon was commended for his Medical Defense Committee work, and *Dr. Earp* for her administration of the Post-Graduate Committee. There was an informal discussion of the Hospitalization Plan.

Dr. Teller, the new President, was enthusiastically received, and was optimistic about the continued success of our work in spite of the difficulties, the result of the National Emergency.

Following the formal meeting, informal discussion, reminiscences, etc., ensued. Some of the members and guests entertained themselves playing with decorated rectangular pasteboards and discs, done in patriotic colors.

PASSAIC COUNTY

Irving Okin, Reporter

A combined meeting of the *Passaic and Bergen County Medical Societies* was held at School No. 13, Paterson, on Thursday, September 11. Dr. Sigurd W. Johnsen and Dr. Harrison Betts Wilson, Presidents of the Passaic and Bergen County Medical Societies, respectively, presided.

The following new members were elected:

Active Membership:

Maurice A. Shinefeld, M.D., Paterson

Associate Membership:

Vincent Feliciano, M.D., Hawthorne

Julianna L. Schwarz, M.D., Passaic

The subject of the evening was "Medical Preparedness". Dr. Charles L. Schlichter opened the program. His topic was "Medical Preparedness—the Physician's Duty in National Defense". Dr. Schlichter pointed out that out of 1080 doctors doing examining work for the draft boards, only seven had resigned in the past year. Ninety thousand selectees have been examined and with a maximum of professional attainment. He pointed out that the Committee was working on the problem of evacuating large numbers of people from industrial areas in the event of an emergency, and that the health of these people would naturally be under the control of the physician. He said that the doctor must back up all civilian defense work and give advice to efforts along medical lines.

Dr. Norman M. Scott then spoke on "An Analysis of the Work Done by the Physicians of the Draft Boards", and pointed out that within 48 hours after the call for physicians to examine selectees had been made, the doctors in the State of New Jersey had been selected and were ready for duty. He brought out the fact that 40 per cent of the men examined have been rejected for physical reasons, up to June 1, 1941. The leading causes for rejections were defective teeth, defective vision, and venereal diseases. He pointed out that a rehabilitation committee was in the process of being appointed, so that for any selectee who wished to have a defect corrected, defense funds would be available for this purpose. This work was now in progress, but no definite action has been accomplished as yet.

The third speaker was Dr. H. Van Zile Hyde, Medical Officer of the Second Civil Defense Area. He spoke of the function of the medical officer in civilian defense. At the present time, this is entirely a planning organization to bring various ideas together and suggest new ideas for states and municipalities to act upon. Plans were being shaped to fit actual conditions and many experiences gained from the British were being used. A weekly news letter will soon be issued. The first bulletin has already been published with recommendations which have been informally approved by the State Medical Society and other civilian organizations. This Bulletin outlines the formation of emergency field stations manned by doctors and nurses. Dr. Hyde pointed out that these would be mobile units, that no fixed stations would be established. He spoke of the necessity for training nurses' aides. These would be individuals who had taken 80 hours of

instruction under competent Red Cross instructors, usually physicians. He said that this course was being expanded so that at least one-half million or more of civilian nurses' aides would be available.

Dr. Sigurd Johnsen then pointed out that Passaic and Bergen Counties have fulfilled all the requirements to date of the preparedness program, and had fully equipped Disaster Units available at a moment's notice.

At 10:00 p.m., a recess was declared to hear President Roosevelt's speech.

UNION COUNTY

Edward G. Bourns, M.D., Reporter

A special meeting of the *Union County Medical Society* was held on September 2 to act upon the death of Dr. James M. Hanrahan. Numerous physicians spoke of the great loss suffered by the community and the profession in the death of Dr. Hanrahan, and the following resolution was unanimously adopted:

Be It Resolved: Almighty God in His Allwise Providence has deemed fit to remove from our midst a beloved friend and colleague, James Michael Hanrahan, who has endeared himself to all by his loyalty, charity and service for the past thirty-one years, regardless of the call. His generosity has been singularly outstanding and his desire for right shall always be cherished in the hearts of those who knew him. His charm and personality will be missed by all with whom he came in contact.

Be It Resolved: That a copy of these resolutions be spread on the minutes of St. Elizabeth's Hospital, to which institution he was ever so faithful at all times, and be it further resolved that a copy of these resolutions be sent to his bereaved family, and also a copy to the press.

The following resolution was also applauded by the Alexian Brothers Hospital:

Be It Resolved: That we, the Medical Staff of Alexian Brothers, record with deep sorrow the passing of Dr. James Hanrahan.

For many years he served as a faithful member of our staff in both the medical and surgical departments and in more recent years as a consultant in our surgical department.

His sterling qualities as a doctor and as a man gained for him the love and respect of his fellow practitioners and patients alike.

Always jovial and conversive, he was a friend of everyone and will be greatly missed by all with whom he came in contact.

To his bereaved family we extend our heartfelt sympathy in this their darkest hour.

WARREN COUNTY

Philip B. Kassow, M.D., Reporter

The regular monthly meeting and outing of the *Warren County Medical Society* was held on July 16 at the summer home of Dr. F. A. Shimer at Lake Hopatcong. Twenty-six members were present. Activities included swimming, boating and a grand dinner.

COUNTY MEDICAL SOCIETIES OF NEW JERSEY

DATES OF MEETINGS, SEPTEMBER, 1941—JULY, 1942

County	Sep.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	June	July
Atlantic	12	10	14	12	9	13	13	10			
Bergen	11	14	11	9	13	10	10	14	12	9	
Burlington	11	9	13	11	8	12	12	9	14		
Camden		7	4	2	6	3	3	7	5		
Cape May	9	14	11	9	13	10	10	14	12	9	
Cumberland		14		9		10		14		9	
Essex		9	13	11	8	12	12	9	14		
Gloucester	18	16	18	18	15	19	19	16	21		
Hudson		7	5	2	6	3	3	7	5		
Hunterdon		28			27			28			28
Mercer		8	12	10	14	11	11	8	13	10	
Middlesex		15	19	17	21	18	18	15	20	17	
Monmouth	24	22	26	24	28	25	25	22	27	24	
Morris		16		18			19			18	
Ocean	10	8	12	10	14	11	11	8	13	10	
Passaic	11	9	13	11	8	12	12	9	14		
Salem	19	17	21	19	16	20	20	17	15		
Somerset		9	13	11	8	12	12	9	14	11	
Sussex	Meets at Call of the President										
Union	24		12		14		11	8	13		
Warren		21			20			21			21

• THE BULLETIN BOARD •

"The Status of New Jersey Doctors in the Point of View of the Medical Preparedness Committee" will be the theme of the meeting of the Atlantic County Medical Society on Friday, **October 10, 1941**. The speaker will be Dr. Charles Schlichter, late Colonel of the Medical Reserve Corps, and now Chairman of the Committee on Medical Preparedness of The Medical Society of New Jersey. All members of the profession are invited to attend this meeting.

• • •

A symposium on poliomyelitis will feature the meeting of the Bergen County Medical Society on Tuesday, **October 14**, at 9:30 p.m. Drs. D. F. Reilly, Nelson Policastro, Frederick Dilger and Phillip N. Stimson will discuss the neurologic, orthopedic and therapeutic aspects of the disorder. The meeting will be held at Bergen Pines in Oradell, N. J., and all members of the profession are invited to attend.

• • •

A conference on diseases of the chest has been scheduled by the Lung Committee of the Essex County Medical Society for Tuesday, **October 14**, at 3:30 p.m. at the Beth Israel Hospital, 201 Lyons Avenue, Newark. Dr. Harry Wessler of New York will be the guest speaker. The conference is open to all physicians.

• • •

New Jersey will play host to the American Public Health Association when this 70-year-old organization holds its annual meeting in Atlantic City October 14-17. This promises to be an especially inspiring meeting, and physicians interested in venereal disease, mental hygiene, communicable diseases, industrial medicine, dietetics, epidemiology and maternal and child health are urged to make plans now to attend this meeting.

• • •

"The Future of America" will be discussed before the Gloucester County Medical Society on Thursday evening, **October 16**, at the Woodbury Country Club, Woodbury, N. J. This is the Society's Annual Social Session and Ladies' Night. The speaker will be Allen A. Stockdale, D.D., a Red Cross Field Director during the World War in France, and a well-known author and clergyman.

• • •

Dr. J. J. Eller will discuss "Dermatology in General Practice" at the **October 22** meeting of the Monmouth County Medical Society, at 9:00 p.m. on that Wednesday evening at the Garfield-Grant Hotel at Long Branch. All members of the profession are invited.

The Association of Military Surgeons of the United States will meet **October 29, 30 and 31** at the Brown Hotel, Louisville, Kentucky. An inspection of Fort Knox is included in the program. The Surgeon General of the Navy will discuss activities of his Medical Department in the national emergency. Responsible officials of the United States Public Health Service, the Veterans' Administration and the War Department will review the rôles of their organizations in military medicine. All members of the medical profession are invited to attend these sessions.

• • •

A conference on Industrial Health will be held **November 5 and 6** at Chicago Towers in Chicago. Included will be a symposium on technical problems involved in health supervision in industry, with an analysis of health services for workers. An inspection of medical departments of Chicago plants is included in the program. Further details may be secured by writing to Mr. A. D. Cloud, Industrial Medicine, 540 North Michigan Avenue, Chicago.

• • •

Dr. Leonard G. Rowntree, Chief of the Medical Division of the Selective Service Division, will speak before the Atlantic County Medical Society, Friday evening, **November 14**, at the Hotel Traymore, Atlantic City. Members of the Society are invited to attend.

• • •

The New Jersey Gastro-Enterological Society will meet on **December 1** at the Jersey City Medical Center, Jersey City, at 8:30 p.m.

• • •

A pamphlet of intimate importance to physicians is available through the Office of Civilian Defense, Washington, D. C. This is entitled "Emergency Medical Service for Civilian Defense", and copies are available for free distribution to physicians who write directly to Washington for them. Ask for "Medical Defense Bulletin Number 1".

• • •

A prize of \$300.00 will be awarded by the American Association for the Study of Goiter to the author of the best original work on any problem related to the thyroid gland, submitted to the Secretary of the Association, Dr. T. C. Davison, 478 Peachtree Street, Atlanta, Georgia. Closing date is April 1, 1942. The article must not exceed 3,000 words and should be typewritten double spaced. This is the Van Meter prize award.

• • •

The Annual Forum on Allergy will be held in Detroit, Michigan, on **January 10 and 11, 1942**.

WOMAN'S AUXILIARY

COMING EVENTS

ATLANTIC COUNTY

October 10, 1941, 8:30 p.m.

Traymore Hotel, Atlantic City

Speaker: Mr. Ben Barken, Instructor of English, Atlantic City High School

Subject: Book review

BERGEN COUNTY

October 21, 1941, 1:00 p.m.

Residence, Mrs. R. U. Berke, Weirmus Road, Ridgewood

Speaker: Dr. Harrison B. Wilson, President, Bergen County Medical Society

Luncheon

ESSEX COUNTY

October 27, 1941, 1:00 p.m.

L. Bamberger and Company

Speaker: Mrs. Becker

Subject: What America Reads

Guests: Drs. Sprague and Weber

MIDDLESEX COUNTY

October 15, 1941, 7:00 p.m.

Roger Smith Hotel, New Brunswick

Speaker: Mrs. Weiman

Subject: Legislation

Guest: Mrs. O. R. Carlander, President, State Auxiliary

Dinner

WARREN COUNTY

October 21, 1941, 11:00 a.m.

Belvidere Hotel, Belvidere

Luncheon meeting with Warren County Medical Society

"A" is for Atlantic County

The first of a series of articles, written by Presidents of County Auxiliaries, to be published each month in these pages. These articles will describe the procedures, aims and pet projects of the County Auxiliaries.

We of Atlantic County are most anxious to see our new project, "Student Nurses' Loan Fund", get under way. In the past, our welfare work consisted of contributing generously to charitable organizations in the county, and beginning in 1940 our plan was changed to something more definite, namely: to aid financially a student nurse in the training school of the Atlantic City Hospital. Since that time our Ways and Means Committee has worked conscientiously and with a great deal of zeal toward that goal and *now* we have accumulated the necessary funds. In September, letters were mailed to principals of all high schools in Atlantic County with the outline of the Student Nurses' Loan Plan. In March, 1942, candidates' names from the various high schools will be submitted to the Nurses Committee. This committee will give each candidate consideration, and in June, on graduation from high school the student will be selected. The Nurses Committee consists of: Superintendent of Nurses, Atlantic City Hospital; Superintendent of Atlantic City Hospital; Chairman of Nurses Committee on Hospital Staff; President of the Auxiliary to the Atlantic County Medical Society. The student will enter the training school in September, 1942. The stipulated amount to be lent the candidate is \$200 for her three-year period of training. A gift of \$25 will be given the nurse by the Auxiliary upon her graduation from the training school.

This year we shall continue our Legislative

Study Group. Each month this group meets and discusses medical legislation; it has proved a most interesting and an enlightening study to all the members of the group. The Legislative Chairman has completed plans for an interesting and informative program for our open meeting in November.

The Medical Preparedness Committee hopes to be of great assistance to the Medical Society. Last year the committee was actively engaged in collecting instruments, drugs, samples and assisting our doctors.

Our members have been doing their bit for the Red Cross by knitting and sewing. We trust that this year we will be as successful in our returns for the Annual Red Cross Roll Call as we have been in the past.

During the summer the Public Relations Chairman has been busily engaged in making contact with all lay organizations in the county. Preparations have been made for an extensive year's program.

It is my hope that the meetings of the Auxiliary to the Medical Society of Atlantic County will be interesting, businesslike and educational; also full of good feeling and sociability. My sincere wish is that Atlantic County shall continue to cooperate and assist the State and National Auxiliaries.

MRS. MORTON MAJOR, President,
Auxiliary to the Medical Society
of Atlantic County.

THE BULLETIN

An informed membership is the first requisite for ordered and intelligent activity. The first issue of "The Bulletin" for the year 1941-1942 has not yet gone to press. Now is the time to subscribe. Send one dollar for one year's subscription to Mrs. Samuel H. Jessurun, 613 High Street, Newark.

STATE BOARD MEETING

An open meeting of the Executive Board of the Auxiliary to The Medical Society of New Jersey will be held in Camden, at 10 a. m., Oc-

tober 13, at the Walt Whitman Hotel. All Auxiliary members are urged to attend.

Warren County

The *Woman Auxiliary to the Warren County Medical Society* enjoyed a joint outing with the members of the Warren County Medical Society on July 16. The party was held at the summer home of Dr. and Mrs. Floyd A. Shiner at Lake Hopatcong, N. J.

On September 16th, the first fall meeting of the Auxiliary was held at the Meadowview Restaurant, Phillipsburg. After the regular business session, during which the activities for the year were planned, the ladies enjoyed luncheon and card playing.

BOOK REVIEWS

The Healing Cults. A Study of Sectarian Medical Practice, its extent, causes and control. By Louis S. Reed, Ph.D. Pp. 134. Chicago, University of Chicago Press. Price: \$2.00.

More than 125 million dollars a year are transferred from the public to the pockets of the chiropractors, osteopaths, naturopaths and assorted cultists. So estimates Mr. Reed in his concise and highly readable study. The author traces the history of osteopathy from its whimsical foundation by Andrew Still to its present status as a discipline with over 8,000 practitioners. The theoretical basis of osteopathy is soberly discussed, and the way in which the cult has managed to accept modern advances in therapy without departing from lip-service to its original philosophy is ingeniously explained. Mr. Reed then tackles the chiropractors, the largest, most articulate group of cultists, who by now number close to 20,000. The devices by which chiropractors manage to keep themselves in practice even in states in which they are theoretically banned are interestingly presented. Another chapter discusses naturopathy, and other drugless healing cults. Next to come under Mr. Reed's scrutiny are the faith healers of all hues, Christian Scientists, New Thought practitioners, and the like.

In a chapter on the cause and control of sectarianism, the author is somewhat less vivid than in his well-written descriptive chapters. He thinks that the factors which drive patients to cultists are superstition, discouragement at the avowed inadequacies of medical care in certain disorders, advertising, the indifference of physicians to minor ailments and the high cost of specialized medical care. To control these cults, Mr. Reed suggests eliminating the causes. However, a glance at the listed catalog of causes will reveal the awkwardness of such a program. Can physicians eradicate superstition or discover how to cure incurable ailments? Should they engage in competing advertising with the cultists? To be sure, his project includes the further advancement of medical science, the culti-

vation of more cordial relations with the public, the readjustment of some of the difficulties in meeting medical costs, and the elimination of the professionally unfit; and in so far as he includes these items, he is entirely right but not especially novel.

The effort to control cultism by legislative enactment and legal enforcement is also carefully reviewed, and the pitfalls of such methods are well presented. The establishment of basic-science laws is the author's preferred recommendation, as he finds that whenever candidates must first pass basic-science examinations, the proportion of cultists clamoring for a license always precipitously drops.

The book is a useful manual for medical society officers, a mine of ideas for medical speakers to lay and legislative groups, and an interesting evening's reading for the curious physician.

Infantile Paralysis. A symposium. Pp. 239 with 49 illus. New York, National Foundation for Infantile Paralysis. 1941.

This book is a collection of the contributions of six authorities whose individual reviews of the current literature, opinions and experience in their assigned fields furnishes a reasonably complete presentation of the most up-to-date knowledge and experience on this very pertinent and perverse subject. It presents compactly and in a form usable to the medical and allied professions and to many others, a valuable source of information at little expense, and is a contribution of distinct merit.

L. A. W.

Science and Seizures. By W. G. Lennox, M.D., Assistant Professor of Neurology, Harvard University. Pp. 258. New York, Harper and Brothers. 1941. Price \$2.00.

Since more than half a million Americans have epilepsy the need for a layman's manual is obvious. The present volume has been written, not as a *vade*

mecum for epileptics, but as an introduction to an understanding of the disorder. The epileptic will not find here any elaborate tables for computing ketogenic diets, nor any neatly boxed series of "do's" and "don't's". But he will find a clearly written and scientifically accurate account of the known physical, physiologic and emotional factors associated with seizures and an assay of the various treatment methods. The author's preferences for electro-encephalographic methods of diagnosis and for dilantin in therapy naturally color the volume. But few can take exception to this, since the value of other treatment measures is fairly discussed, and no wild claims are made for the electro-encephalogram.

About 200 pages are devoted to epilepsy, and 40 to migraine. The two conditions are considered "biologically and genetically related". The author hopes that the social acceptability of migraine may serve to blunt some of the stigma which so unreasonably attaches to epilepsy. Indeed, much of the volume is a plea for eliminating this sense of shame about epilepsy.

Lennox is clearly committed to the principle that epilepsy and presumably migraine, too, are due to a cerebral dysrhythmia, manifested by alterations in the pacing of electric discharges from the brain. This he implements by a presentation of electro-encephalographic tracings which will be helpful to the practitioner unfamiliar with this latest development in neurophysiology.

Lennox discusses the problem of heredity, but carefully evades a categorical answer to the query: may an epileptic have children? He states that seizures are five times as frequent among close relatives of epileptics than among the general population, which suggests that parenthood is a serious risk for epileptics. Then he recalculates to show that an epileptic can have 36 children with the chances that only one will be epileptic.

Therapies by dehydration, ketogenic diet, and by mental and physical hygienic measures are reviewed. The chapter on drug treatment emphasizes dilantin, bromids and phenobarbital. The effectiveness, toxicity and dosage control of the three are well presented. The social-psychologic aspects of the management of epilepsy are carefully treated. Such practical but usually neglected facets of the problem as the cost of medication are considered. On the social front, the author reviews the occupational problems of the epileptics, and questions, in passing, the effectiveness of legislation which requires doctors to report all epileptics so that their automobile licenses may be revoked. He points out that this will merely discourage epileptics from seeking medical care, and that it is just as logical to require physicians to report all alcoholic patients to their motor vehicle officials.

Much attention is devoted to "The Campaign Against Epilepsy" with stress on methods of changing public attitudes towards the disorder. The author includes a frank plea for the support of the Laymen's League Against Epilepsy.

The brief section on migraine highlights the hereditary factor in this disease. "Most migraine victims," he writes, "are born that way." Ergotamin tartrate is suggested as the most effective of the single drug remedies.

Although "Science and Seizures" is intended for the layman, few physicians will find the volume too elementary. Indeed, most general practitioners will find here a clearer exposition of modern concepts in epilepsy than he will find in any other single work.

HENRY A. DAVIDSON, M.D.

Community Organization for Health Education.

The report of a committee of the Public Health Education Section and the Health Officers Section of the American Public Health Association. Pp. 120 with 12 illus. Cambridge, Technology Press.

In reviewing *Community Organization for Health Education*, one is impressed with the conviction that Health Education is a complex concept and should be broken down into component parts. As a suggestion: (1) Pedagogic methods for schools; (2) publicity and promotion concerning procedures in emergencies (first aid) and for disease prevention for industrial workers, housewives, and other adult groups in a community, and (3) individual health improvement, protection or restoration.

The first of these categories is the job of the school teacher, to be carried on as a regular part of educational process with subject matter selected and approved by recognized medical authorities.

The second category embraces the pertinent instruction in the home, factory and other centers for adults, and concerns the most urgent needs of the moment to combat hazards to which each group is exposed. Since the Health Officer and his staff periodically survey their assigned area to determine the current health hazards, he is the logical executive to integrate all efforts in the three special categories of the health education effort in his area.

The third category concerns the individual who seeks information and advice regarding his personal needs. This involves a careful history taking and analysis of the pertinent influences and effects upon the individual in *past* experiences. His *present* concern and complaints and their relation to his present environment and activities, diet, hygiene and aims.

These facilities exist in most communities, and the urgent problem is to establish the most effective and economic scope of function for each agency and then to integrate the approved activities of each agency into a community health education program.

This publication is an honest effort in this direction and, as such, is a contribution to organized effort. The reviewer suggests as an early additional step, that effort be made to reach agreement on the relative importance of the various activities now being conducted in various communities since our criterion for health is largely the *absence* of signs and symptoms of disease and defects.

L. A. W.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XIV

October, 1941

No. 10

EXPERIENCE in the First World War taught us the importance of discovering tuberculosis among military men. When the Selective Service Act went into effect, the Navy was requiring a chest roentgenogram for all enlisted and commissioned men, and the Army for the commissioned personnel only; facilities for routine roentgenography of all men were not at first available. Among the civilian agencies which supplemented the efforts of the Army in this emergency was the Bureau of Tuberculosis of the New York City Department of Health. A record of that organization's experiences is published in the Journal of the American Medical Association from which these abstracts are taken.

X-RAYING MILITARY MEN

An order issued October 28, 1940, by the Adjutant General's Office of the United States Army made it possible for civilian organizations to set up a roentgenographic service for men inducted into the Army. It provided for payment for x-ray films and for the services of civilian roentgenologists (under due control) until such time as the Army could assemble its equipment and assume full responsibility.

The Bureau of Tuberculosis of the New York City Department of Health has been engaged in mass roentgen-ray surveys of the apparently healthy population since 1933. These surveys have been accepted as a basic part of the tuberculosis control program of New York City and thus interest, based on experience, in providing a similar service for inductees and members of the State National Guard was rife. Accordingly, the Bureau's mass roentgen-ray services, which were made possible through the WPA, were offered to the Surgeons of the Second Corps Area prior to the Adjutant General's directive that was issued on October 28, 1940. Financial assistance was received from the tuberculosis associations of Queens and the Bronx.

After January 1, 1941, the Army assumed full financial responsibility for the roentgen-ray service in induction centers. The Department provided personnel for the interpretation of films. Since January 15 this service has also been taken over by the Army, which has assigned medical reserve officers qualified in this special field. The

roentgenographing of National Guardsmen has been entirely at the expense of the Department of Health. Under existing regulations the Army could not pay for this service until after induction, and it was important that rejections be made before induction.

At the outset there were four induction stations. Since January 1, 1941, all work has been done in two stations, one in Manhattan and one in Queens.

Those rejected men who were residents of New York City were given an appointment within the next two or three days to appear at the Health Department's Central Chest Clinic, where a complete study of the case was made. If this examination proved the original findings to be of no significance, the local draft board was so notified.

Rapid roentgenographic service was necessary as the recruit was supposed to be cleared through all examinations by 2:30 p. m. of the day he reported at the induction station. With from 60 to 300 men per unit to be handled daily, even the rapid roll method used in the routine survey program was inadequate. Consequently a special type of apparatus was devised. A modification of the roll paper camera was used in connection with a specially constructed portable dark room measuring 8 by 8 feet with the back of the camera integrated into one side of the dark room. A signal device was installed between the roentgen-ray technician and the dark room. As soon as a

film was exposed, the signal was flashed and the dark room crew cut off the film and placed it in the developing bath. The signal was then reversed, indicating that another film was ready to be exposed. A team of three, consisting of a technician and two dark room assistants, were able to operate faster than one exposure a minute. The films were processed in large trays and from the fixing bath were passed out to the physician through a light-proof pass. After being read, the films were washed in a portable tank and dried in a special device designed for the purpose.

Acceptance or rejection was based on Army regulations. Men showing any form of reinfection types of tuberculosis were rejected because lesions of such types may become aggravated under conditions of military service. Primary lesions considered as active or extensive calcifications were likewise cause for rejection. Other forms of significant pulmonary disease, such as bronchiectasis, pneumonitis, atelectasis or extensive pleural changes, were cause for rejection until further study could determine their importance. Men with obviously abnormal cardiac silhouettes were reported to the medical examiners for such further study as might be indicated. Men with nothing more than apical caps, and those with small well-healed primary lesions were not rejected.

The group of men examined up to January 15, 1941, during which the Department of Health was actively engaged in the program, included 6,609 inductees and 9,541 Guardsmen, a total of 16,150 individuals who were x-rayed.

Of the inductees, 1.36% were rejected and of the Guardsmen, 1.21%. About one-third of the Guardsmen were below the age of 21, while only about 0.5% of the inductees were below that age. An all-Negro regiment (National Guard unit) had the highest mean age in all groups and the highest rate of rejection, which was almost entirely on the basis of pulmonary tuberculosis. If the findings in this unit are subtracted from the totals of all Guard units a greater difference will be found between Guardsmen and inductees.

Classification by stages of disease of the 70 men considered clinically significant shows that 65.7% were minimal, 32.9% moderately advanced and 1.4% far advanced. Primary lesions indicated by calcific deposits were found in 6% of the white men, 8.7% of the Negroes and 7.1% of the Puerto Ricans.

The group of men examined since January 16 and through March 31, 1941, totaled 35,210 men. During that period the Department of Health's part has been to re-examine and classify New York City men rejected at the induction center. In this time 458 men have been rejected, 379 of whom have thus far been cleared at the Health Department Clinic. In 49, or 12.9% of those re-examined, the cause for rejection at the induction station was not confirmed and the man was considered suitable to be accepted in the Army from the standpoint of his roentgenogram.

A detailed cost analysis of personnel, equipment and materials necessary to complete this study indicated a total of \$23,614.20. Using this as a basis for computation, the unit cost to examine each individual by roentgenogram was \$1.47. (The cost of taking a roentgenogram and its interpretation without any further follow-up was \$13,911.20, or 58.8% of the total.) The unit cost of rejecting a man for military service on the basis of the total cost was \$106.02 for inductees and \$122.37 for Guardsmen.

Spillman has reported that the cost to the Federal government of accepting a person with tuberculosis into the armed service is \$10,000. Thus, in these studies involving 41,819 inductees and 9,541 Guardsmen, or a total of 51,360 men, 561 persons with chronic pulmonary tuberculosis were rejected, representing an estimated saving to the government of \$5,610,000.

Examinations for Tuberculosis by Herbert R. Edwards, M.D., and David Ehrlich, M.D., Jour. of Amer. Med. Assn., July 5, 1941.

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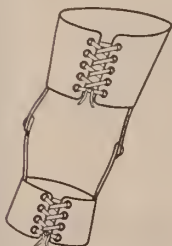
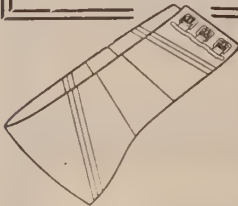
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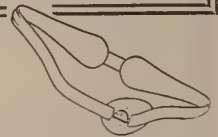
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1. Knight, F., and Shelanski, H. A., "Treatment of Acute Anterior Urethritis with Silver Picrate," Am. J. Syph., Gon. & Ven. Dis., 23, 201 (March), 1939.

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TOMATO JUICE AND ACIDOPHILUS MILK

T.A. overcomes the distaste some patients have for the flavor of plain acidophilus milk.

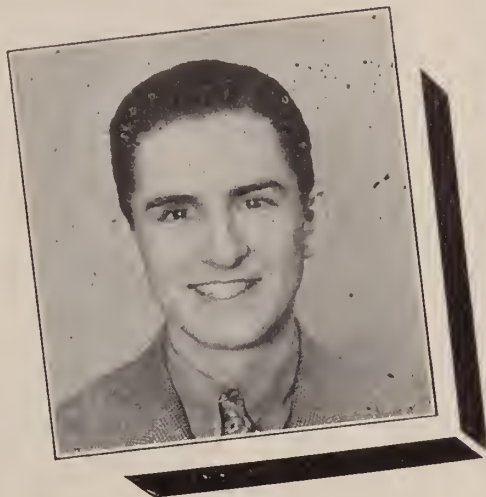
T.A. provides an ample supply of the beneficial acidophilus bacilli—more than 500,000,000 per c.c.

T.A. also provides, in a single pint, vitamins A, B₁, and D in amounts sufficient to meet the usual needs for health, regardless of any extra

vitamins obtained from balance of diet: A—4,000 U.S.P. units; B₁—333 U.S.P. units; D—400 U.S.P. units. Also a substantial amount of vitamin C.

T.A. is made fresh every day at the Walker-Gordon Laboratories; it is delivered by the Borden milkmen. For further information, write Walker-Gordon Laboratories, Plainsboro, New Jersey.

Full-Motioned, Lifelike **ARTIFICIAL HUMAN EYES**



We have the Enviably Reputation of "Really Knowing How" to produce that "Pleasing Cosmetic Effect" so desired by one wearing an Artificial Eye.

REFERRED CASES CAREFULLY ATTENDED

IT IS OF VITAL IMPORTANCE TO THE PATIENT'S FUTURE APPEARANCE THAT THE FIRST ARTIFICIAL EYE BE PROPERLY FITTED. IT IS IN THESE NEW CASES, WHERE UTMOST ATTENTION MUST BE GIVEN—AND OF WHICH WE HAVE MADE A SPECIAL STUDY.

Especially Made to Order Eyes by Skilled Artisans.

Also Eyes Fitted from Stock

SELECTIONS SENT ON MEMORANDUM UPON REQUEST.

FRIED AND KOHLER, INC.

"Specialists in Artificial Human Eyes Exclusively"

665 FIFTH AVENUE
near 53rd St.

NEW YORK, N. Y.
Tel. Eldorado 5-1970

"Pleasing Particular People for Over Forty Years!"

KARO FORMULAS FOR NORMAL INFANTS

AGE—TWO WEEKS

Milk 10 ozs.
Water 10 ozs.
Karo syrup 2 tbs.
3 ozs. every 4 hrs.—6 feedings

AGE—ONE MONTH

Milk 12 ozs.
Water 13 ozs.
Karo syrup 2½ tbs.
4 ozs. every 4 hrs.—6 feedings

AGE—TWO MONTHS

Milk 15 ozs.
Water 13 ozs.
Karo syrup 3 tbs.
4½ ozs. every 4 hrs.—6 feedings

AGE—THREE MONTHS

Milk 17 ozs.
Water 9 ozs.
Karo syrup 3 tbs.
5 ozs. every 4 hrs.—5 feedings

AGE—FOUR MONTHS

Milk 20 ozs.
Water 11 ozs.
Karo syrup 3½ tbs.
6 ozs. every 4 hrs.—5 feedings

AGE—FIVE MONTHS

Milk 23 ozs.
Water 11 ozs.
Karo syrup 4 tbs.
6½ ozs. every 4 hrs.—5 feedings

AGE—SIX MONTHS

Milk 26 ozs.
Water 10 ozs.
Karo syrup 4 tbs.
7 ozs. every 4 hrs.—5 feedings

The amount of Karo in each formula is optional. During the summer, it may be reduced according to the baby's digestive reaction.



A FORMULA of whole cow's milk, carbohydrate and water may be calculated for the individual infant according to the following requisites:

- (1) The amount of cow's milk necessary will be 1.5 to 2.0 ounces per pound (100 to 130 cc per kilo) of expected body weight per day; or, one-half to two-thirds of the total calories required for the infant.
- (2) The amount of added Karo syrup required will be about one-tenth of the quantity of milk used, i.e., 0.15 to 0.2 ounces per pound (0.1 to 1.13 grams per kilo) of expected body weight per day, or one-third to one-half the total calories required for the infant.
- (3) The total caloric value of the formula should be approximately 50 to 55 calories per pound (110 to 115 calories per kilo) of body weight per day.
- (4) The amount of water added to the formula will be two to three ounces per pound (130 to 200 cc per kilo) of body weight per day; and the amount of water added to the formula for the 24-hour period depends upon the degree of dilution required to render the mixture digestible.
- (5) The amount of formula offered at a feeding during the first few months is expressed by the rule—Age in months plus two ounces at four-hour intervals."

KUGELMASS: "Newer Nutrition in Pediatric Practice." 1940.

CORN PRODUCTS SALES COMPANY

17 Battery Place, New York City

PROFESSIONAL
LIABILITY
PROTECTION

Afforded Members of
THE MEDICAL SOCIETY OF
NEW JERSEY

Since 1921

FAULHABER & HEARD, INC.
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FAULHABER & HEARD, Inc.

31 CLINTON STREETNEWARK, N. J.

Kindly send information on limits and costs of Society Professional Policy.

Name

Address



"At the menopause 80 per cent of women experience general symptoms of varying character and intensity¹."

AMNIOTIN

**Relieves
Menopausal
Symptoms**

JEFFCOATE,¹ in a paper on estrogenic hormone therapy, states that 80 per cent of women experience menopausal symptoms varying from the well-recognized vasomotor disturbances to those of vaguer character such as headaches, emotional instability, depression, anxiety and muscle pains. In a large percentage of cases these symptoms can be eliminated by adequate estrogenic therapy.

During the more than 10 years in which Amniotin has been available to the medical profession its clinical effectiveness in controlling menopausal symptoms has been abundantly

demonstrated. It differs from estrogenic substances containing or derived from a single crystalline factor in that it contains, in highly purified form, estrogenic substances naturally present in pregnant mare's urine. Its estrogenic activity is expressed in terms of the equivalent of international units of estrone.

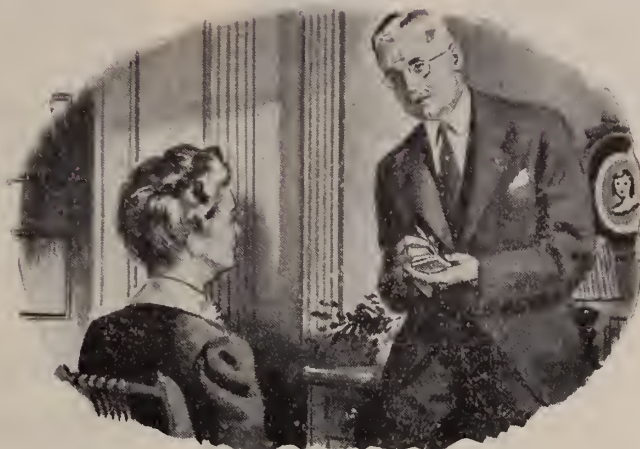
Amniotin is available in Capsules containing the equivalent of 1000, 2000 and 4000 I. U. of estrone; in Pessaries containing 1000 and 2000 I. U. and in 1-cc. ampuls containing 2000, 5000, 10,000 and 20,000 I.U.

¹ Jeffcoate, T. N. A.: *Brit. Med. J.* 2:671 (Sept. 30) 1939.

*For literature address the Professional Service Department,
E. R. Squibb & Sons, 745 Fifth Avenue, New York, N. Y.*

Amniotin

A SQUIBB PREPARATION OF ESTROGENIC SUBSTANCES
OBTAINED FROM THE URINE OF PREGNANT MARES



Q. I've heard that some varieties of canned marine fish are good sources of vitamin D. Is that true?

A. Yes, it is. A four-ounce serving of canned salmon contains approximately 200 to 800 U.S.P. units of vitamin D-2. The body oils of sardines approach a good cod liver oil in vitamin A and D potencies. Therefore, canned sardines are another important dietary source of vitamin D. (1) It has been reliably estimated that the amount of canned salmon sold in this country alone contains more vitamin D than the cod liver oil used for both animal and human feeding. (2)

American Can Company, 230 Park Avenue, New York, N. Y.

(1) 1935, J. Home Econ. 27, 658.

(2) 1931, Ind. Eng. Chem. 23, 1066.



The Seal of Acceptance denotes that the nutritional statements in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.



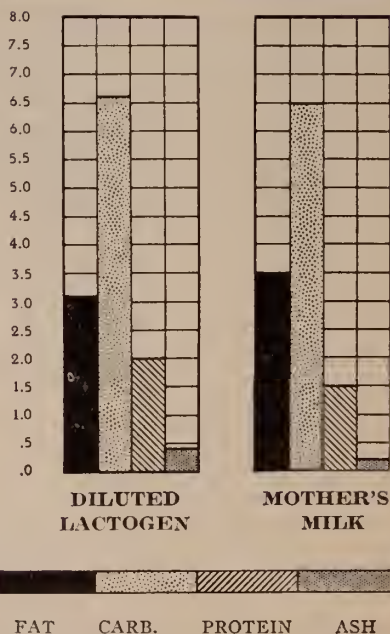
LACTOGEN
approximates
women's milk in the
proportion of
food substances

THE COW'S MILK used for Lactogen is scientifically modified for infant feeding. This modification is effected by the addition of milk fat and milk sugar in definite proportions. When Lactogen is properly diluted with water it results in a formula containing the food substances—fat, carbohydrate, protein, and ash—in approximately the same proportion as they exist in woman's milk.

No advertising or feeding directions, except to physicians. For free samples and literature, send your professional blank to "Lactogen Dept.," Nestlé's Milk Products, Inc., 155 East 44th St., New York, N. Y.

"My own belief is, as already stated, that the average well baby thrives best on artificial foods in which the relations of the fat, sugars, and protein in the mixture are similar to those in human milk."

John Lovett Morse, A.M., M.D.
Clinical Pediatrics, p. 156.



NESTLÉ'S MILK PRODUCTS, INC.

155 EAST 44TH ST., NEW YORK, N. Y.

THE NATURAL MINERAL WATERS OF SARATOGA SPA ARE
OWNED AND BOTTLED BY THE STATE OF NEW YORK



SARATOGA SPA NATURAL MINERAL WATERS

for

Repairing Mineral Deficiency as in Pregnancy

In pregnancy, the value of the natural mineral waters of Saratoga Spa makes itself felt with particular emphasis. The unique natural carbonation makes them palatable and encourages the patient to take the full prescribed amount.

The richness of their mineral content is displayed in the tabular analyses of the three waters, as shown below. All are of saline-alkaline type, but variable as to total mineralization and saline-alkaline ratios.

The labile form of the contained minerals encourages their assimilation. This is a mineralization impossible of artificial duplication. Ready evidence lies in the fact that, once evaporated out of solution, the salts are not again entirely soluble. That is why the State bottles the natural mineral solutions, and seals them under their own natural CO₂ pressure. No air can touch them until the bottle is uncapped.

For professional literature, write W. S. McClellan, M.D.,
Medical Director, Saratoga Spa, 159 Saratoga Springs,
New York.

Analysis of the Three Waters

(MINERAL PARTS PER MILLION)

Hypothetical Combinations	Geyser Water	Hathorn Water	Coesa Water
Ammon. chlorid	48.25	59.10	33.30
Lithium chlorid	21.07	64.49	46.43
Potass. chlorid	361.91	789.54	714.86
Sodium chlorid	2,010.48	8,594.84	4,233.14
Potass. bromid	9.23	160.00	13.90
Potass. iodid	1.10	4.80	1.36
Sodium sulphate	None	None	None
Sod. metaborate	Trace	None	Trace
Sodium nitrate	Trace	Trace	Trace
Sodium nitrite	Trace	Trace	Trace
Sodium bicarb.	2,213.78	424.71	1,331.15
Calcium bicarb.	1,829.14	3,380.84	2,519.74
Barium bicarb.	16.67	25.65	25.00
Strontium bicarb.	Trace	Trace	Trace
Ferrous bicarb.	9.94	40.07	5.86
Magnes. bicarb.	753.89	2,244.88	1,186.57
Alumina	7.14	4.98	6.37
Silica	19.40	14.40	12.80
Total	7,284.00	15,808.30	10,130.48

Look for the Seal of The State of New York on every bottle of the genuine waters of Saratoga Spa.



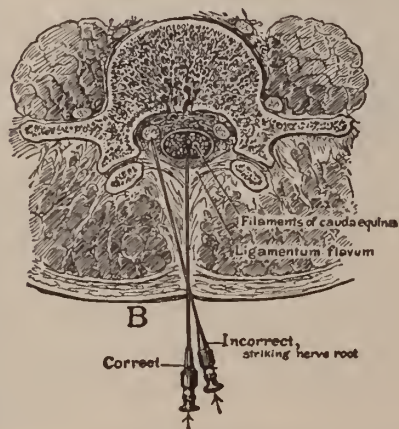
THE BOTTLED WATERS OF
SARATOGA
SPA

GEYSER • HATHORN • COESA

TRYPARSAMIDE MERCK

Two Decades of Service in Neurosyphilis

DIAGNOSIS



Lumbar Puncture

- From *The Modern Treatment of Syphilis*, by Joseph Earle Moore, M.D. Charles C. Thomas, Springfield, Ill., and Baltimore, Md., 1933. By courtesy of author and publisher.

CHEMOTHERAPY



ADVANTAGES

- Unusual power of penetration, especially in case of the central nervous system.
- Prominent status in the therapy of neurosyphilis.
- Does not require hospitalization when used alone.
- Easy to administer.
- Inexpensive.
- Available to patients through the services of their own physicians.

LITERATURE ON REQUEST



MERCK & CO. Inc.

Manufacturing Chemists

RAHWAY, N. J.

Are you familiar with this new FOUR-ACTION vaginal therapy?



BETANAL VAGINAL CAPSULES embody therapeutic principles of proven efficacy in the treatment of many leukorrheal disorders, including trichomoniasis, senile vaginitis, certain types of cervicitis, and cervical erosions.

The prompt efficacy of Betanal in vaginal therapy is due to its four-fold action:

1. Betanal promotes growth of normal flora.
2. Betanal aids in restoring normal acidity.
3. Betanal helps maintain epithelial carbohydrate.
4. Betanal acts to dry vaginal walls and promote healing.

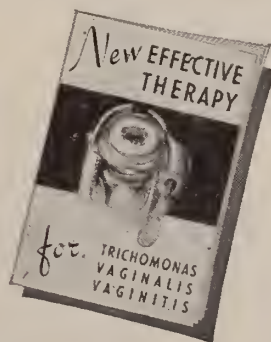
Betanal is convenient to use, contains no strong chemicals, is stainless, odorless, and non-irritating. Each capsule contains 220 gr. Borden's Beta Lactose and 55 gr. boric acid.

WRITE FOR BOOKLET DESCRIBING NEW BETANAL THERAPY

This descriptive booklet fully explains how the 4-point action of Betanal is effective in helping to restore natural vaginal defenses and promote healing. It also discusses the specific indications for prescribing Betanal, the method of use, and the clinical advantages in gynecological therapy.

FOR YOUR COPY of this booklet and sample of Betanal write The Borden Company, 350 Madison Avenue, New York, N. Y.

Betanal is available at any pharmacy in packages of ten capsules.



BETANAL VAGINAL CAPSULES

A BORDEN PRESCRIPTION PRODUCT

*A typical Lederle development—***SERUM REFINING**

SERUM SICKNESS used to be a serious obstacle to the successful application of serotherapy. So great was the fear of these reactions that at times the patient was even deprived of life-saving treatment.

From 1906 to 1934 the "salting out" method of serum refining was virtually unchanged. It remained for Lederle's staff, long experienced in the problems of serum production, to establish firmly the value of a new process of serum refining. This process, based upon the phenomenon of peptic digestion, removes up to 90% of the troublesome proteins believed responsible for untoward serum reactions. Globulin Modified Antitoxins refined by this method may be expected to cause a minimum of reactions. They are higher in potency, smaller in volume and of greater clarity than previous antitoxins.

But serum refining is only one of many Lederle biological achievements. Antitoxins, serums, vaccines and toxoids from Lederle's 200-acre serum farm protect countless individuals from the ravages of disease all over the world.



LEDERLE LABORATORIES, INC.
30 ROCKEFELLER PLAZA
NEW YORK, N. Y.





WHY THE GUILD OPTICIAN?

Any EYE PHYSICIAN will tell you that 50% of the eye comfort of his prescription is due to the proper fitting of the glasses. Accurate fitting is essential not only to comfort but to good vision. But the most accurately made glasses will get out of adjustment from time to time. That is why you need expert fitting such as is available at all times at any GUILD OPTICIANS.

Doctor, here is your winning combination, EYE PHYSICIAN, GUILD OPTICIAN. You can never fail your patients with this advise to them.



EYE PHYSICIANS: Your prescriptions for glasses are "Safe" when referred to a Guild Optician.

Guild of Prescription Opticians of New Jersey, Inc.

ASBURY PARK
ANSPACH BROS.
552 Cookman Ave.

ATLANTIC CITY
FREUND BROS.
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CAMDEN
PELOUZE & CAMPBELL
116 N. Broadway
J. E. LIMEBURNER Co.
535 Cooper St.
E. F. BIRBECK Co.
5th & Cooper Sts.

EAST ORANGE
ANSPACH BROS.
533 Main St.
HAROLD C. DEUCHLER
541 Main St.

ELIZABETH
BRUNNER'S
277 N. Broad St.

ENGLEWOOD
FRED G. HOFFRITZ
30 Park Place

HACKENSACK
HOFFRITZ & PETZOLD
315 Main St.

JERSEY CITY
WILLIAM H. CLARK
26 Journal Square

MONTCLAIR
STANLEY M. CROWELL Co.
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RALPH E. MARSHALL
5 Church St.

MORRISTOWN
JOHN L. BROWN
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ANSPACH BROS.
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J. J. KEEGAN
33 Central Ave.

J. C. REISS
10 Hill St.
CHARLES STEIGLER
11 Central Ave.

PATERSON
J. E. COLLINS
241 Market St.

PLAINFIELD
GALL & LEMBKE
633 Park Ave.

SUMMIT
ANSPACH BROS.
212 Bassett Building
H. C. DEUCHLER
344 Springfield Ave.

WESTFIELD
BRUNNER'S
206 Broad St.

"SEE YOUR DOCTOR." Reproduced below is Number 171 of a series of full-page advertisements published by Parke, Davis & Co. In the interest of the medical profession. This "See Your Doctor" campaign has been running in *The Saturday Evening Post* and other leading magazines for thirteen years.



The man who nearly died . . . from a few kind words

BYOND THAT DOOR lies a very sick man. True, his doctor says he is going to pull through. But he has come mighty close to paying a tragic price for a few words of free advice from a well-meaning friend.

When he complained of a nagging pain in his abdomen, his friend said: "You've probably eaten something that's poisoned you. Here's what I'd do . . ."

So he promptly followed his friend's suggestion and took a cathartic. And in a matter of hours he was being rushed by ambulance to the hospital . . . with a ruptured appendix.

His friend, of course, had acted from the kindest of motives. But he didn't know that an abdominal pain might mean acute appendicitis, in which case a cathartic should never be taken.

Unfortunately, appendicitis is only one of many illnesses where amateur medical advice can result in tragedy. Yet, human nature being what it is, many people just can't resist the temptation to offer advice when a friend is sick.

Intelligent medical treatment depends upon various factors which only a physician is qualified to evaluate. When something

seems wrong with you, it is the part of wisdom to observe this common-sense rule: Take a friend's advice about buying a radio, a car, or even a home if you wish; but don't let him advise you about your health.

Don't let a friend who *means* well tell you how to *get* well. To get well, and *keep* well, the man to see is your physician.

Copyright, 1941, Parke, Davis & Co.

PARKE, DAVIS & COMPANY
Detroit, Michigan

*Seventy-five years of service to
medicine and pharmacy*

SEE YOUR DOCTOR

"When the frost is on the punkin . . ."



The pollens are gone with the frost and your allergic patients breathe freely again. But with the fall come colds and upper respiratory infections, and to obtain relief from the nasal congestion from these causes you will again have need of a reliable decongestant.

Local application of Solution Racêphedrine Hydrochloride (Upjohn) to nasal mucous membranes diminishes hyperemia and reduces swelling. In many cases Capsules Racêphedrine Hydrochloride (Upjohn) are also useful in ameliorating these symptoms.

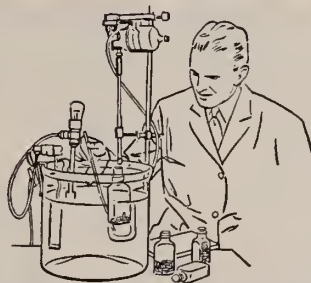
**RACÊPHEDRINE HYDROCHLORIDE
(UPJOHN)**

is available as:

Solution Racêphedrine Hydrochloride (Upjohn) 1% in Modified Ringer's Solution, in one ounce dropper bottles for prescription purposes, and in pint bottles for office use

Capsules Racêphedrine Hydrochloride (Upjohn), $\frac{3}{8}$ grain, in bottles of 40 and 250

Powder Racêphedrine Hydrochloride (Upjohn), in $\frac{1}{4}$ ounce bottles



Determination of gelatin solubility is one laboratory test in the assay of finished capsules.

Upjohn
KALAMAZOO, MICHIGAN



Fine Pharmaceuticals Since 1886

KOROMEX DIAPHRAGM



KOROMEX TRIP-RELEASE INTRODUCER

TIP TURNS
ON SWIVEL

Holland-Rantos
Company, Inc.

551 Fifth Avenue

New York, N.Y.

An Effective Medicinal Weapon Against Depressions

Mild pathological depressions may accompany a variety of clinical syndromes. In addition to prescribing whatever forms of therapy are indicated for the individual condition, it may also be advisable to treat the underlying or concomitant depression.

If, in the judgment of the physician, treatment of this depression appears advisable, the administration of Benzedrine Sulfate Tablets will often prove useful. In depressive psychopathic cases the patient should be institutionalized.

Benzedrine Sulfate Tablets offer "a therapeutic rationale which, in its very efficiency, cuts across the old categories". (Parker, M. M.—J. Abnorm. & Soc. Psych., 34:465, 1939)

Initial dosage should be small, 2.5 to 5 mg. If there is no effect this should be increased progressively. "Normal Dosage" is from 5 to 20 mg. daily, administered in one or two doses before noon.

Benzedrine Sulfate Tablets are now manufactured in two sizes. In writing prescriptions please be sure to specify the tablet-size desired, either 5 mg. or 10 mg.



Benzedrine Sulfate Tablets

Brand of amphetamine sulfate



SMITH, KLINE & FRENCH LABORATORIES, PHILADELPHIA, PA.

100 YEARS OF SERVICE TO



THE MEDICAL PROFESSION



*Treatment of disease,
to a great extent, is
built on confidence.
The patient believes
in the competence of
his physician, and
the doctor, in turn,
relies upon the com-
pany whose products
he prescribes.*

SECONAL

(Sodium Propyl-methyl-carbinyl Allyl
Barbiturate, Lilly)

'Seconal' fulfills the requirements for a hypnotic in the majority of medical and surgical patients. Action is prompt, the period of sleep is restful, aftereffects are negligible. 'Seconal' has definite uses in insomnia, nervousness, extreme fatigue with restlessness, and similar conditions where only a brief sedative effect may be required to allow onset of natural sleep.

Supplied in 3/4-grain and 1 1/2-grain pulvules in bottles of 40 and 500.

ELI LILLY AND COMPANY

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

PUBLISHED MONTHLY SINCE SEPTEMBER, 1904

Whole Number of Issues, 447

UNDER THE
DIRECTION OF THE
COMMITTEE ON PUBLICATION



HENRY C. BARKHORN, M.D., Chairman

HENRY A. DAVIDSON, M.D., Editor

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EXECUTIVE OFFICER—LEROY A. WILKES, M.D.

EXECUTIVE ASSISTANT—NORMAN M. SCOTT, M.D.

Each member of the State Society is entitled to receive a copy of THE JOURNAL every month.

VOL. XXXVIII, No. 11

NOVEMBER, 1941

Subscriptions, \$3.00 per Year
Single Copies, 30 Cents

SALUTE TO THE WOMAN'S AUXILIARY

The quiet and modest way in which the Woman's Auxiliary works often obscures the value of their contributions both to organized medicine and to the community at large. This modesty is commendable, but it is time that The Medical Society recognized, and the public learned, of the highly effective work being done by the Woman's Auxiliary to The Medical Society of New Jersey. Our women are daily performing tasks which should be acknowledged by the community. It would be well if the County Auxiliaries sent to their local newspapers properly prepared releases telling the world what they are doing for public welfare.

From the public point of view the most conspicuous of the good works of the Auxiliary is their donation of gifts and money to worthy causes. Even a partial list of the beneficiaries of their efforts will surprise most of us. Thus, in the past year the following agencies and individuals have received gifts, money or equipment from the Woman's Auxiliary:

Children's Homes, Visiting Nurses As-

sociation, British War Relief Association, Hospitals, Nurses' Homes, Red Cross, Widows and Orphans of Doctors, hospitalized ward patients, soldiers in camps in New Jersey, the Tuberculosis League, the Girl Scouts, Cancer Control organizations, libraries, patients in need of blood transfusions, Y. W. C. A.'s, and the benevolent funds of the Medical Societies themselves.

The Auxiliaries of Atlantic, Burlington, Mercer, and perhaps other counties, have established funds to help worthy student nurses receive their professional education. This is philanthropy of the most constructive sort and it is an investment in human character. The special Blood Transfusion Fund of Ocean County is a unique and truly life-saving philanthropic project. The gift of food, recreational equipment and clothing to both British and American soldiers is a highly practical contribution to National Defense. Through special questionnaires, the Auxiliary will classify its members with reference to skills useful in National Defense programs, particularly in con-

nection with evacuation and sabotage projects.

Even these imposing contributions, significant as they are, do not represent the totality of their services. The Auxiliary is of inestimable value to The Medical Society in dozens of other ways, too. They secure medical speakers and forums for the profession's public relations campaign. They promote friendly relationships among physicians' families, this work reaching a high-spot each year when they arrange for the banquet at the Annual Meeting of The Medical Society of New Jersey. They keep running the wheels of our Clinical Conferences by serving as hostesses, registrars and guides.

The proportion between the size of each County Medical Society and the much smaller size of the corresponding Auxiliary is strange. Perhaps doctors are at fault in not more fully activating their mothers, sisters and wives to joining the Auxiliary. If so, the fault should be corrected, for the Auxiliary is an indispensable member of our large New Jersey medical family. Incidentally, doctors are reminded of the fact that the *Journal* contains an Auxiliary section which Auxiliary members are anxious to read. Make the *Journal* accessible to your women-folk.

We may never have said so before. If so, let it be said now. We know the full worth of the Auxiliary; we are grateful to them.

PREPARING FOR THE WORST

Doctors above all others know how wise it is to prepare for the worst while still hoping for the best. New Jersey is uncomfortably, but not unreasonably conscious, of what that "worst" might mean in the event of any increasing acuity of the national emergency. Our state's vulnerability arises from the fact that it is the bridge-way between the country's metropolis and the nation's capital; that it is the home of several strategic airports; that it contains in its southern portion an agricultural area that must serve as part of the breadbasket of the East; while its northern district teems with industrial concentrations. New Jersey is proud of the shipyards, docks, airports, factories, and forts which it houses. But there is no blinking at the fact that these very facilities are magnets of potential danger to our citizenry.

In any disaster, the medical profession will have a man-sized job. Let the job be uncomplicated by diversion of our time and energy into functions for which we are not especially trained or into duties already assigned to others.

These things we can do: We must have stores of medical equipment and drugs, accessibly located in hospitals or other centers; when needed, we must be at hospitals and field centers, not alone at disaster sites; we must use our energies in giving medical care, not in performing types of accident-control work for which other personnel is provided; and finally, we must see to it that there is available an adequate supply of physicians and physicians' aides.

It would be a blow to efficiency if we were to divert our efforts into such functions as traffic control, evacuation techniques, camp construction, sewage control, bomb-shelter architecture, or moral policing. There is no reason to believe that we doctors would be especially successful at any of these specialized tasks. But if we can throw into vivid focus the performance of these essentially medical tasks: first aid, surgical care, direct treatment, and the medical manning of disaster units, if we can do these—we shall be making yeoman contribution to civilian defense.

COMMERCIAL EXHIBITS

Commercial exhibits at a medical convention are much more than three-dimensional advertisements. The doctor who is loudest in his protest against advertising devices must admit, in a confidential moment, that he has found in these exhibits specific and concrete data about drugs and supplies which were not otherwise easily obtainable. The development of new advances in pharmacology and medical equipment has, in the true pattern of the American Way, been largely a function of private industry. And these new medications and new accessories are first presented to the profession through the enterprise and advertising of the commercial exhibitor. It seems likely that without the competition and promotion of the manufacturers, we would be much poorer today in our knowledge of such preparations as insulin, epinephrin, sulfanilamid, vitamins, endocrines, and the like.

Behind the window represented by his commercial exhibit, the manufacturer is engaged in enormously expensive research into medical science, the fruit of which is ultimately available to the doctor and the patient. True, these companies have not engaged in such research out of purely altruistic motives. But the fact remains

that they have financed and promoted much that is priceless in modern medicine.

Medical Societies thus need no apology for the presentation of commercial exhibits. No modern medical convention would seem complete without them. They are the Rialto of the convention, and they furnish education and entertainment, a floor for discussion, a lobby for the meeting of old friends, and not incidentally, the financial wherewithal which pays for the convention itself. They deserve our interest and attention.

That New Jersey doctors have not been unappreciative of this is attested in part by the fact that within a week of announcing booth space, every available square foot was engaged by the commercial exhibitors for the 1942 Annual Meeting, even at the unusually early date made necessary by the American Medical Association convention in Atlantic City. It is to be noted that no space is rented for the exhibit of any product deemed unacceptable by the American Medical Association.

It appears that New Jersey doctors enjoy these exhibits; and that the exhibitors appreciate the interest of the New Jersey doctor.

THE "AMERICAN WAY" PROGRAM

Last month The Medical Society of New Jersey brought to successful consummation the largest single public relations project in its history. This, of course, was the delivery of 84 addresses to as many Kiwanis clubs. The talks were focussed on the topic "The American Way of Distributing Medical Care". It is estimated that about 4000 Kiwanians heard these talks. Most of the speeches received adequate newspaper notice, and many of them were reprinted in full in the press. Never before has our Society

had the chance to present the medical-care problem to so large an audience at one time.

The job of preparing scripts, selecting speakers, assigning the talks, securing the publicity, adjusting calendar conflicts, taking care of last-minute changes, and furnishing factual material to the speakers was a huge one, and was made possible by effective team-work between the Public Relations Committee of the State Society and the corresponding committees of the county organizations. Ulti-

mate credit, of course, goes to the men on the front line, the individual practitioners, who gave their time to prepare and deliver the talks. It is with the purpose of expressing profound gratitude to these helpful members of our Society that this note is written. A list of the speakers appears on page 590 of this *Journal*. They deserve every word of gratitude and praise that we can give them. Thanks are also due the county

societies, particularly their public relations committees and speakers' bureaux. And, all important were the Kiwanis Clubs themselves, who provided us with this far-flung forum. The results were gratifying; and the spirit of co-operation and reciprocal helpfulness was a heart-warming demonstration.

PUBLIC RELATIONS COMMITTEE,
The Medical Society of New Jersey.

MUTINY ON THE BOUNTY

Buried beneath a mass of dry statistics, we noticed a report recently that our large "Foundations" are now devoting a third of their money-grants to medical research, medical teaching and other facets of the healing art. The same study also reveals that education, for decades the pet project of the "Foundations", has been ousted from the number one position by medicine, which is now their prime beneficiary. This solicitude is matched only by increasing government concern with medical care, and our pro-

fession is thus the victim of an embarrassment of riches.

Now this is all very flattering, and at first glance, very comforting. Second thought, however, reveals a faint cloud in the horizon. It seems that the man who pays the piper is still entitled to call the tune on any request program. Can it be that the philanthropists and politicians who are opening the purse, are also anxious to dictate the policies? Or is this petulant query just another Mutiny on the Bounty?

ACKNOWLEDGMENTS FROM LEGISLATORS

The Sub-Committee on Legislation has received many letters from Senators and Assemblymen who read with interest the editorial on page 495 of the October *Journal*. Several of these communications

expressed warm appreciation of the Society's attitude. The Sub-Committee on Legislation takes the opportunity of thanking the legislators for their acknowledgments.

ORIGINAL ARTICLES

OPERATION OF A BLOOD BANK *

TWO YEARS' EXPERIENCE

By LESTER M. GOLDMAN, M.D.; PHILIP LEVINE, M.D.; HELMUTH SPRINZ, M.D.,
and WILLIAM ANTOPOL, M.D., Newark, N. J.

The use of preserved blood for transfusion dates back to World War I.¹ Nevertheless it was not until the establishment of the blood "bank" at Cook County Hospital in 1937² as an outgrowth of the preservation of cadaver blood by Yudin³ that its practical application became popular. Shortly thereafter we became interested in the value of the "bank" plan and after careful consideration for more than a year, a service of this nature was instituted at the Newark Beth Israel Hospital in December, 1938. It has been in operation continuously since that time to the satisfaction and approval of both the clinical staff and the transfusion group.

THE BLOOD BANK

The blood bank depends upon the establishment of a continuous supply of bloods of all groups. This reserve is constantly maintained by donors provided by the patient's family. Blood is not sold but is exchanged for blood to be provided by a donor.

OBTAINING AND PRESERVING THE BLOOD

The blood is obtained from donor relatives or friends of the patient. The donor need not necessarily be of the same blood group as the patient for whom he is replacing blood. The administration and operation of the blood bank are centralized in the laboratory.

Two phlebotomy periods per week are provided for this service, one on Monday evening, the other on Friday morning. When the donor

comes, he registers, giving his name, the patient's name and that of his family doctor; he signs a waiver which permits use of the blood for patients other than his relative. Next, his blood is grouped. His blood is then collected in an open Mason jar with bakelite cap and paper cup for sealing. The anticoagulant in use now is 20 per cent sodium citrate solution (10 cc. to 500 cc. of blood). At the time of phlebotomy, blood is also collected in two small test tubes, one firmly affixed to the bottle with adhesive tape for direct cross-matching to be done just prior to transfusion, and the other sent to the laboratory for the Wassermann test and recheck of the blood grouping. The bottle of blood is then placed in quarantine in the refrigerator until the serology report returns; if it is positive, the blood is discarded, and the donor's family physician notified; if negative, the blood is released for use.

The blood is preserved at a temperature of 2 to 4° C. in an ordinary 9 cubic-foot electric refrigerator provided with a thermostat and control gauge. The number of bloods kept on reserve is approximately that used during an average week's demand.

TRANSFUSION TECHNIQUE

When a transfusion is requested the patient is promptly grouped and his blood cross-matched by the Landsteiner method, directly with that of the attached test tube of a blood of corresponding group. The blood is then promptly delivered to the patient's room where the transfusion is performed. An intravenous infusion is set up with a small amount of normal saline. The blood is gently agitated and warmed slightly, and then added to the infusion through a sterile funnel provided with a gauze filter. Saline is added at the end of the transfusion

* From the Division of Laboratories, Newark Beth Israel Hospital, Newark, N. J.

1. Robertson, O. H.: Transfusion with Preserved Red Blood Cells. *Brit. M. J.*, 1:691 (June 22) 1918.

2. Fantus, Bernard: The Therapy of the Cook County Hospital: Blood Preservation. *J. A. M. A.*, 109:128 (July 10) 1937.

3. Yudin, S. S.: Transfusion of Cadaver Blood. *J. A. M. A.*, 106:997 (March 21) 1936.

to wash through the blood remaining in the set.

It was decided to discard unused refrigerated bloods at the end of ten days due to changes in the blood demonstrated both clinically and experimentally.

OBSERVATIONS AFTER TWO YEARS OF SERVICE

In 1939, the first year of the blood bank, 705 transfusions were performed; in the second year the number increased to 885. The latter figure contrasts with that of the year preceding establishment of the bank (1938) during which only 728 were given. From discussions with the clinicians it appears that the increase in requests is due to the greater availability of blood for transfusions as a result of the ease with which donors are obtained. The relatively few requests during the first year were admittedly due to the hesitancy of the clinical services to accept the newer method; but after due trial, their experience dictated that the technique was at least as satisfactory as the previous more direct methods.

The relative distribution of blood groups in donors corresponds for practical purposes with that of the general population. Of all the transfusions, only 230 or about 15 per cent received blood of unlike groups (O to A, O to B, etc.). From this, it is apparent that donor group distribution corresponds well enough with recipient groups to make all blood groups (with the exception of AB) available at almost all times.

About 76 per cent of all bloods used were stored for six days or less. Only about three per cent of bloods were more than ten days of age; all of these were administered during the first six months of operation of the "bank". In the first two years of operation only 96 or 5.6 per cent of the bloods were discarded for age. In the same interval 22 or 1.3 per cent were discarded because of positive serology and 14 or 0.8 per cent used for experimental purposes.

EXPERIMENTAL FINDINGS ON BLOOD PRESERVATION

Studies were made over a period of 30 days on the stability of blood components during preservation with several anti-coagulants. De-

terminations were made at three-day intervals. The anti-coagulants studied were sodium citrate (10 cc. of 20 per cent solution to 500 cc.), heparin, and liquoide "Roche" (sodium polyanetholsulfonate); observations were also made with 2.5 per cent glucose added to each of these anti-coagulants.

From this work, it appeared that the erythrocytes remained intact in sodium citrate solution alone for the longest period, showing the least change in resistance to hypotonic salt solution; that leucocytes deteriorated most gradually with liquoide, as did the granulocytes in particular; that platelets were best preserved in liquoide and heparin, remaining fairly constant throughout; that the prothrombin content of the blood in sodium citrate showed very gradual fall, remaining fairly normal for about 12 days. It was also apparent that the addition of glucose enhanced the preservation of all components to some degree. In a study⁴ of the survival of transfused erythrocytes it was noted that cells preserved longer than 10 days could not be detected in recipient blood after two to three weeks.

Since the disappearance of glucose was very gradual in all cases, reaching a maximum loss equivalent to about 1 per cent solution in 30 days, it was felt that the addition of this amount as a maximum was most desirable.

These data will be published in more detail later in a paper now in preparation in collaboration with J. Churg, W. Lipstein and M. Ashkenazy.

REACTIONS

Probably the greatest question in the minds of the clinician regarding the efficacy of this method was the possibility of post-transfusion reactions. For this reason, in the early days of the bank any untoward behavior on the part of the patient was interpreted as a transfusion reaction. Despite this, total incidence of reactions (including any temperature rise of 1°) was only 117 or 7.4 per cent of the 1564 transfusions, a figure comparing favorably with the experiences of clinics using citrated unpreserved blood. In only one case was there shock and chill which could possibly be interpreted

⁴. Unpublished observations of P. Levine, M.D., and C. Englander, M.D.

as a transfusion reaction. Analysis of reactions in relation to age of blood indicates no apparent increase of incidence up to the tenth day. There was a greater proportion of reactions in patients of group AB. It is interesting that in this group of 51 transfusions, blood of an unlike group was used in 38 instances.

While it is difficult to evaluate the beneficial effect of blood transfusion on any one patient, the general clinical impression suggests that the effects following this method compare favorably with the use of more direct methods.

ADVANTAGES TO THE PATIENT

1. Blood of all groups is constantly available without delay. This is especially valuable in extreme emergencies such as shock, hemorrhage, etc.
2. The blood bank removes the need of a frantic search for donors.
3. It reduces the cost of transfusions. The transfusions themselves are less costly; and the need for professional donors is less since a relative or friend of any group may serve as a donor to replace blood.
4. Multiple transfusions, when desirable, are more possible since blood need not be replaced immediately.
5. The procedure prevents the possibility of transfusion syphilis in emergency transfusions.

ADVANTAGE TO THE DONOR

The donor comes to the laboratory without haste, without the need of being rushed to the hospital by an emergency call and with the knowledge that if he is disease-free his blood will be acceptable regardless of type.

ADVANTAGES TO THE DOCTOR

1. Technique is simplified.
2. Diminished cost makes use of transfusion more available.

3. Time in emergencies is saved because numerous groupings are not required.

ADVANTAGES TO THE HOSPITAL

1. The procedure simplifies technique.
2. Use of operating room is unnecessary.
3. Available blood removes the confusion of search for a satisfactory donor.
4. Is of marked economic advantage: fewer linens and other materials are used; and there is no cost for donors for indigents.
5. The same organization may be utilized for the maintenance of a plasma bank.

DISADVANTAGES

1. The transfusion technique is limited to one method.
2. By removing sensationalism, it increases difficulty in obtaining volunteer donors.
3. There are alterations in blood elements during preservation.
4. Is not practical in the small hospital.
5. There is some unavoidable loss of blood due to positive serology, age, etc.
6. The fact that the transfusion has already been given often causes delinquency in the replacement of blood.

CONCLUSION

After two years of trial, the blood bank was found to operate successfully at the Newark Beth Israel Hospital. It has been used uniformly for all patients, both private and ward. It has solved a number of the problems which had presented themselves for many years in the blood transfusion service. In the event of an emergency this service may be expanded with ease to care for many times its present load, even to the extent of providing for patients outside of the hospital.

SOME FUNDAMENTAL ASPECTS OF RADIATION BIOPHYSICS AND BIOCHEMISTRY

By CHARLES ODERR, M.D., Westfield, N. J.

Read before the Section on Radiology of the Annual Meeting of The Medical Society of New Jersey,
in Atlantic City, June 5, 1940.

Since biology is an expression of physical and chemical phenomena, radiation effects must be an expression of changes in these phenomena. Improvement in rational methods of treatment by radiation is dependent upon a clearer understanding of these changes. In this paper, we shall discuss the vulnerability of a cell from the viewpoint of the size of its vital area, the amount of its mineral content, and the stability of its organic molecular structure. We shall also consider briefly the vulnerability of the tumor as a whole, and of the tumor bed,—as influenced by time and dose relationships in clinical practice.

VULNERABILITY OF THE CELL

Size of Vital Area: To cause the death of a cancer cell, it is necessary to produce a certain degree of ionization and chemical change within a vital portion of that cell. The same amount of energy dissipated in a non-vital portion will not be lethal. This is equivalent to saying that to cause the death of a man, it is necessary to produce a certain amount of damage to his heart muscle; the same amount of damage to a leg muscle will not be fatal. Therefore, the *total amount* of absorbed energy is not as important as the *degree of concentration* at vital points. To illustrate the concept of sensitivity in a vital point in a cell, the genetic changes that result from radiation of *Drosophila* eggs is a good example. (Footnote 1.)

It has been shown by Gowan (Duggar¹¹) that the probability of a photon or unit of radiant energy causing genetic changes in a

germ cell of the *Drosophila* corresponds roughly to the probability of its hitting an object in the cell about the size of a gene. The number of such gene-sized areas in a cell is relatively few, varying from two thousand to fifteen thousand per cell. If we imagine a gene placed in a deep layer of homogeneous organic material where radiation, in a photochemical sense, can never be very intense, it is evident that it might escape being hit on the basis of probability. Then, if multiple hits were necessary to destroy the gene, its chances of survival would be increased many times.

Amount of Mineral: On the other hand, if instead of being homogeneous, the organic material surrounding the gene contained mineral atoms capable of producing a very concentrated sphere of radiation, there would be a good chance for multiple hits within a short time interval. Such a condition exists in most biological material. The amount of mineral varies tremendously; that is, the mineral atoms in some tissues may be sufficiently numerous to provide a strong probability of producing very concentrated radiation through vital points—and in other tissues, insufficiently numerous for this purpose. A study of this variation in mineral content, therefore, becomes of considerable importance in radiation therapy. In embryonic tissue, for example, micro-incineration studies have shown that mineral content is not uniform. There is a concentration of minerals in the regions of rapid growth, which are likewise the most radiosensitive areas.

Considering cells individually, it has been demonstrated by Scott³⁴ that the nuclei of embryonic cells leave denser mineral residues than those of adult cells.

1. Genetic changes resulting from radiation very frequently result from production of lethal genes. This is probably the most frequent mode of cell death, unless very large doses of radiation are given.

2. This probably occurs by a breaking of the bond between the calcium atom and carboxyl group of an amino acid in the protein molecule.

In addition to producing small areas of soft concentrated radiation, a consideration of tissue minerals is necessary from another point of view. Minerals are important in cell physiology, and changes in the amount and distribution of calcium, sodium, and potassium may cause fundamental changes in the biological dynamics of the cell. Changes in amount and distribution of minerals may be brought about by radiation treatment.

Calcium in the form of a protein salt is known to perform an important function in maintaining the semipermeability of the cell wall; radiation tends to free this calcium from its combination with the protein molecule. (Footnote 2.) Two important results follow this molecular disintegration—namely, an increase in the permeability of the cell wall, and a migration of calcium ions into the cytoplasm. This increased permeability caused by the loss of calcium from some of the molecules composing the cell wall may account for the increase in the other minerals found in the cytoplasm at certain periods after radiation, which, in turn, produce biological disturbances. (Footnote 3.)

In the case of rabbit skin, Meltzer and Kuhtz²⁵ found a maximum increase in minerals at thirty-one hours, after which there was a drop in mineral content. This built up again to a maximum at the end of twelve days. In the case of the transplantable mouse tumor, adenocarcinoma Number 27, radiation causes an increase in cytoplasmic mineral residue in

from six to eight hours. The maximum increase, as reported by Horning (Scott³⁴), is reached on about the sixth day.

Having caused increased permeability by leaving the cell wall, calcium then produces secondary effects by virtue of its increased concentration in the cytoplasm. It first raises the viscosity of the cytoplasm, and then, if the concentration is increased still further, it favors coagulation. The function of calcium here is probably the same as in coagulation of blood, because the other prerequisites for coagulation are the same in cytoplasm as in blood.

The function of minerals other than calcium may be equally important, but is not as well understood at the present time.

Thus, minerals play a double rôle in the radiation effect. First, they produce small areas of very soft radiation which concentrates the destructive effect; and second, they undergo a redistribution which is injurious to the tissue. If, after radiation, a cell lives beyond the period of maximum mineral increase (the twelfth day in the case of rabbit skin), a decrease occurs and equilibrium is again established, possibly with less total mineral than was originally present. When this happens, it is probably an important factor in the diminished sensitivity found at the time of subsequent radiation.

Stability of Organic Molecular Structure: Of greater importance than minerals in radiosensitivity is the character of the large organic molecules of the cell, which are composed chiefly of carbon, hydrogen, oxygen, and nitrogen arranged in extremely complex molecular structures.

The secrets of life and growth are bound up in the intricacies of these molecules. According to Hammett,¹⁷ growth can be divided into five inter-related phases, each one of which appears to be governed by one or more amino acids. He suggests that cancer may be a deficiency disease in the sense that it lacks, or is unable to use, certain organic radicals needed for balanced growth. Thus, as Reiman³³ speculates, the factors of growth initiation and proliferation might be present without the balancing influence of factors favoring organization and differentiation, which are found in all nor-

3. Such increased permeability to metallic ions may be useful in accentuating the chemotherapeutic effect of agents which have a selective action on malignant cells. It has been known for some time that colloidal lead (now used in combination with manganese and iron) is more effective when given in conjunction with x-ray treatment (Kraemer²⁷). It is conceivable that some of the metals known to form salts with the amino acids might be used to remove them from the cell economy. Silver could be used to form a salt with arginine, and incidentally is practically the only metal capable of doing so. If, therefore, it should be desirable to inhibit the action of arginine, a logical procedure would be the injection of silver at a time when the permeability of the cell wall would be at a maximum. A resistant lesion might by some such method be converted into a sensitive one.

mal tissue. Both neoplastic and normal tissue presumably contain the factors for the fifth phase of growth, that of regeneration. Because of better organization, normal tissue regeneration should have an advantage. (Footnote 4.) No direct experimental data are available concerning the effect of radiation on these various phases of growth, or on the radiosensitivity of the organic radicals which represent them. We do know that the breakdown of acids by enzymes involves a certain degree of specificity. That is, a given amino acid may be dissociated by one enzyme in one way, by a second enzyme in another way, and by a third enzyme, not at all. Dissociation of organic complexes, such as amino acids, by radiant energy is probably less specific, but yet has undoubtedly definite limitations. These limitations must be concerned with the stability of the molecular structure—greater stability manifesting itself as radioresistance. (Footnote 5.)

If such a concept is valid, radiotherapy should be directed toward dissociation of the amino acids and other compounds favoring the tumor growth. (Footnote 6.) The use of tissue or bacterial enzymes may offer an auxiliary method of breaking down the offending radicals. Unfortunately, the compounds necessary

for the repair process in the normal tissue would probably also be dissociated. If these compounds were known, however, it might be possible to supply extra quantities of them in concentrated form at favorable times after treatment. Should it become possible to promote the health and growth of normal tissue in this manner, the full force of the natural antagonism of normal tissue for invading tissue could be utilized.

We have discussed so far three theoretical considerations:

1. The probability relationship that exists between radiation as it appears in the depth of a biological subject, and the vulnerability of cell integrity.

2. The possible significance of minerals in the phenomena of radiosensitivity and radioresistance.

3. The concept of correlation between a specific molecular structure and various observable phases of growth, with the theory that strength and stability of molecular structure is the determining factor in resistance or sensitivity to radiant energy. (Footnote 7.)

VULNERABILITY OF THE TUMOR AS A WHOLE, AND OF THE TUMOR BED

(TIME AND DOSE RELATIONSHIPS)

Upon an increase in knowledge of the factors governing the vulnerability of the cell depends the development of rational formulae for treatment of the tumor as a whole. We have very little basic data available with which to approach the problems of intensity, interval between treatments, period of time for a complete series, and total dose. We can, however, approach them from a clinical point of view.

Intensity of Radiation: In human or animal subjects, in contrast to experimental material such as *Drosophila* eggs, intensity of radiation is a factor of prime importance. This may be

4. Normal epithelium will start to grow over a neoplastic ulcer while radiation is in progress, and cancer cells are still being destroyed. Ewing has attributed this to the greater adaptability of normal tissue.

5. Radiation effects are usually not subject to chemical analysis but can be determined after a variable length of time by the biological consequences. This may even require observation over several generations. It is particularly true of more resistant cells. It is possible that this variation in stability of structure may be related to isotopism: The units of a given atom may often be organized in numerous ways without changing the basic chemical characteristics of the element. Some atomic forms are very unstable, changing readily into other more stable conformations. Similarly, some molecular structures are unstable and undergo rapid changes (Pauling²⁸). The molecules of very young embryonic tissue are probably characterized by such a lack of stability. They are, therefore, more easily changed by the forces of environment than adult tissue. With age and environmental contact, configurations of more solidity and strength are probably formed (Beutner,¹ Bordier,³ Holthusen,¹⁹ Melnick and Bachem,²⁴ Pickham,²⁹ Ralston³²).

6. Certain enzymes and viruses could be included here. (Herzberg and Thelan,¹⁸ Murphy,²⁶ Hadden and Robinson¹⁵).

7. The discharge of positive colloidal particles in protoplasm by negative radio ions is an important radio-biological phenomenon not discussed in this paper. It can be considered as one of the ways by which the essential biological characteristics of the organic complexes are destroyed.

related to some type of "multiple hit" phenomenon as described by Lea.²² That is, quanta of energy, arriving at the same place at certain intervals of time, are more effective than if the same number of quanta arrived at either shorter or longer intervals. (Footnotes 8 and 9.) In support of this, Friedman¹³ found that continuous twenty-four hour, low-intensity radiation with a radium pack was about 20 per cent more effective than the same dose delivered in one hour. Experimental work by Gregori¹⁴ and Zacharias³⁷ has shown that very short alternating periods of treatment and rest are definitely more effective than the same amount of radiation, given with the same intensity, but by continuous exposure. Low-intensity treatment and alternating treatment of the type just mentioned may therefore be effective in similar ways. (Footnote 10.)

Interval between Treatments: For the sake of convenience, we have usually adopted a twenty-four-hour period, or a multiple thereof, as the interval between treatments. Intervals of one day are, as a rule, more desirable than longer intervals.

Amount of Daily Dose: The minimum dose which must be given at each treatment has been established in some instances. When possible, this should be stated in terms of tumor dose rather than in terms of air or skin dose—since the depth of the tumor has a marked influence on the amount of radiation it receives. Generally the more resistant the tumor the larger the necessary daily dose.

The required daily dose is greater, also, as the end of the series of treatments is approached, because at this time the more sensi-

tive cells have already succumbed and only the resistant cells remain. It should be borne in mind that even the most sensitive tumors may contain some cells which will equal, or even surpass in resistance, the cells of a resistant tumor.

Period of Time for Complete Series and Total Dose: The optimum period of time for the total treatment and also the amount of the total dose, should be determined for every type of tumor. With resistant lesions, results are better when the total dose can be given within a short period. Coutard^{8,9} has pointed out that the total dose for a resistant lesion is not necessarily greater than that required for a so-called sensitive one.

These data offer interesting possibilities for correlation with the variation in mineral content brought about by radiation. The period of maximum mineral increase after radiation may be found to form the basis of a rational guide to the time to be allowed in completing a series of treatments. The correlation with organic molecular structure is a more difficult problem, and much progress must be made in other fields before this can be contemplated.

The problems concerning treatment of the tumor as a whole,—namely, intensity, interval between treatments, daily dose, total period of treatment, and total dose—are complicated to a great extent by the character of the *tumor bed*, by which is meant the normal cells which lie adjacent to the neoplastic cells. If a cure is to be obtained, the tumor bed must not only prove resistant to invasion, but must also be capable of healing over the defect left by the tumor. The factors involved in protecting the tumor bed have been badly neglected. If a tumor spontaneously invades an ischemic area such as cartilage or bone, it is, in a sense, unavoidable; but to artificially induce an ischemic area adjacent to a malignant lesion by cutting into or around a tumor or metastasis when it cannot be totally removed, is extremely

8. The question of optimum intensity for any one treatment is a matter of great dispute. Coutard feels very strongly that in no case should a rate of about 10 r per minute be exceeded.

A slow rate is more important with resistant lesions than with sensitive ones.

9. According to Failla (Duggar¹¹), high intensity of radiation within reasonable limits does not diminish the ionization effect due to immediate recombination of the positive and negative ions. This is because there is no appreciable crossing of the ionization paths produced by the photoelectrons. By the same reasoning, we should not expect any increase in the concentration of ionization from crossing paths, with high intensity radiation.

10. It is possible that more experience with the method of "alternating treatment" will show that an economy of time can be accomplished without sacrifice in results. The simplest method of producing an alternating effect would probably be by means of a rotating lead sector disc.

unwise. To determine whether or not a tumor mass is totally removable requires an understanding of its biological nature, as well as a knowledge of its anatomical limits. This is obtainable by a study of all available evidence in the history and physical examination—in addition to which, the response to small doses of radiation is often helpful as a guide.

SUMMARY AND CONCLUSIONS

The investigation of radio-biology in discrete cells tends to indicate that the principal effects of radiation are produced by destroying vital areas in the cell which are very small in comparison with the total size of the cell.

From general biophysical considerations, we have suggested that the sensitivity of a vital area in a cell is proportional to the stability of its molecular structure. For any given vital area, a certain concentration of radio-ionization would be necessary for a lethal effect. The

presence of adjacent mineral atoms would greatly facilitate the production of the required concentration of radio-ionization.

The therapeutic effect of radiation may be partly due to a redistribution of minerals in the tissues. This redistribution of minerals follows a definite pattern which is completed in a certain period of time. More complete knowledge of this phenomenon may prove helpful in establishing the optimum period of treatment. It is to be remembered that the radio-biology of the cells of the tumor bed is equal in importance to that of the cells of the tumor itself.

Up to the present time we have been concerned chiefly with the factors of intensity, interval between treatments, daily dose, total dose, and total period of treatment. In the future, we shall probably be concerned also with the utilization of chemicals in combination with radiation.

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THE TUBERCULOUS INDIVIDUAL

By HILTON S. READ, M.D., F.A.C.P., Ventnor, N. J.

Read before the Pine Rest Staff Meeting, Northfield, N. J., January 9, 1941.

In a world that is busy committing suicide, it is good at times to stand still, blink our eyes, scratch our heads, and jolt our work-a-day minds out of their ruts.

Maybe I am wrong in thinking it worth your time to consider the *Tuberculous Individual*,—that human host to a little organism 1-10,000th of an inch long and 1-50,000th of an inch wide, the discovery of which was made by Koch just sixty years ago. But, in our scientific zeal, we have busied ourselves with that organism and its tissue reactions, forgetting, on occasion, the illness of the human being who is its host.

Since 1936 Pine Rest has admitted 245 patients. There are now in the sanatorium forty-nine patients. There have been 116 deaths, or a mortality in the sanatorium of 47 per cent. Maybe it is the realization which came to me recently that, in fifteen years, I had seen the members of this hospital staff evolve into a hard-working, serious, scientific, truth-seeking staff, with an almost consuming passion for attendance upon the clinical sessions and clinical work. Certain it is that my ward rounds for the past two years have paid me handsome dividends on the time invested. Certain it is that the mounting brick and concrete of this impressive new *Haven of Hope*, this new Pine Rest, that is soon to be our workshop, has served to crystallize my thinking, and to impress me with our new opportunities and the attendant responsibilities we are about to assume.

It is quite natural, I suppose, that reflection upon the metamorphosis of Pine Rest should start me thinking of the evolution of phthisiology in general. And as is my habit, when this thinking is too profound for my mind, I foreswore the hustle and bustle of Absecon Island, and took the veil amid the musty book stacks of the Philadelphia College of Physicians. Before you condemn or chuckle at my Alice-in-Wonderland enthusiasm for such a browsing trip, try it yourself, and see what it

does for you. The gentle rhetoric of the old medical authors, the soothing language of the medical pioneers, the courteous profundity, the masterful projection of the possibilities, the elaboration of theses that are mirth-provoking in the light of what we like to consider present-day super-science, even the cough-producing dust of these old volumes—all these, like fine old Sherry, produce a most delightful intoxication.

Maybe you would join me in a chronologically haphazard, and very informal, visit with some of our forebears in the field of tuberculosis.

THE EARLY GREEK PHYSICIANS

The infective nature of tuberculosis was recognized by some early Greek physicians. For example, a physician of the time of Aristotle asked:

"Why are those who are brought in contact with the sufferers, taken by phthisis, and not taken by such diseases as dropsy, fever, and apoplexy, however close the contact with sufferers from these diseases may be? Phthisis is obviously infectious, because it spoils the air and makes it heavy, and thus others become infected."

That such views as these were generally prevalent may be gathered from a speech by Isocrates, who based the claim of his client to inherit his father's estate on the fact that he had nursed him while suffering from phthisis, although his friends had dissuaded him saying that most of those who nurse in this disease themselves succumb to it.

Galen clearly held that phthisis was an infective process, and that it was a danger to live with those who suffered from it. Aphrodiseus declared that the phthisical patient sends out during the expiration, bad air, which, being rebreathed by a healthy person, would in turn convey the disease to him. But Aritaeus the Cappadocian (50 B. C.) left a description of the advanced tuberculous which cannot be improved upon today:

"Voice hoarse; neck slightly bent; tender, not flexible, somewhat extended fingers, slender, but joints thick; of the bones alone the figure remains, for the fleshy parts are wasted; the nails of the fingers crooked; the pulps are shriveled and flat, for owing to the loss of flesh, they neither retain their tension nor rotundity; and, owing to the same cause, the nails are bent, namely, because it is the compact flesh at their points which is intended as a support to them; and the tension thereof is like that of the solids. Nose sharp, slender; cheeks prominent and red; eyes hollow, brilliant and glittering; swollen, pale or livid is the countenance; the slender parts of the jaws rest on the teeth as if smiling, otherwise, of a cadaverous aspect. So also, in all other respects, slender without flesh; the muscles of the arms imperceptible; not a vestige of the mammae; the nipples only to be seen; one may not only count the ribs themselves, but easily trace them to their terminations, for even the articulations of the vertebrae are quite visible; and their connections with the sternum are also manifest; the intercostal spaces are hollow and rhomboidal, agreeably retracted; the abdomen and flanks contiguous to the spine; joints clearly developed, prominent, devoid of flesh; so also with the tibia, ischium, and humerus; the spine of the vertebrae, formerly hollow, now protrudes, the muscles on either side being wasted; the whole shoulder blades apparent like the wings of birds. If in these cases, disorder of the bowels supervenes, they are in a hopeless state. But if a favorable change takes place, symptoms the opposite of those fatal ones occur."

PREVENTIVE PHTHISIOLOGY 1782

Here is an interesting binding entitled "Causes of Tuberculosis" from the Library of the Philadelphia College of Physicians. Among the brochures bound herein is a historical paper read before the American Public Health Association in 1890 by Lawrence F. Flick,¹ of Philadelphia. I quote the opening few sentences, which reflect the opinions held 150 years ago:

"On July 19th, 1782, the sovereign of the kingdom of Naples gave his sanction to a legal enactment for the prevention of tuberculosis, which, according to De Renzi, the medical historian of Italy, contained the following propositions:

"1. That the physician shall report the consumptive patient, when ulceration of the lungs has been established, under penalty, for the first offence of 300 ducats; and upon repetition, of banishment for ten years.

"2. That an inventory shall be made by the authorities of the clothing in the patient's room, to be identified after his death, and if any opposition shall be made, the person doing so, if he belongs to the lower class, shall have three years in the

galleys or in prison; if to the nobility, three years in the castle and a penalty of 300 ducats.

"3. That household goods which are not susceptible shall be immediately cleansed; and those that are susceptible shall at once be burned and destroyed.

"4. That the authorities themselves shall tear out and replaster the house, alter it from cellar to garret, carry away and burn the doors and wooden windows and put in new ones.

"5. That the sick poor shall at once be removed to a hospital.

"6. That newly-built houses cannot be inhabited before one year from their completion, and six months after plastering has been finished and repairing has been done.

"7. That superintendents of hospitals must keep in separate places clothing and bedding for the use of consumptives. Other severe penalties are threatened to those who buy or sell objects which had been used by consumptives. Other severe penalties are threatened to those who buy or sell objects which had been used by consumptives, to servants, members of the family, and to any transgressor whomsoever."

EARLY AMERICAN WORKS

One later book is "A Treatise of Scrofulous Disease, by C. B. Hufeland, M.D." It was published in 1829. Interestingly enough, it was translated by Charles D. Meigs, M.D. It was stated therein that among the best means of treatment were emetics. I was also intrigued by the appendix entitled "On Crookedness of the Spine—Its Cause and Treatment". Cause VII was "Too frequent or long rides in a jolting carriage over rough roads."

This next book is the Boston Edition of Louis² on Phthisis. It was published in 1836. I will read to you one sentence from the section on "The Treatment of the More Prominent Symptoms of Phthisis", which reads: "Under this division we shall include haemoptysis, expectoration, cough and diarrhea." Apparently there has been little change in the disease when these are still the things that provoke and exhaust our therapeutic efforts.

The next book³ was published in 1855 by W. C. & J. Neff, 3½ South Seventh Street, Philadelphia, Pa. I quote its title page:

1. The Prevention of Tuberculosis: A Century's Experience in Italy under the Influence of the Preventive Laws of the Kingdom of Naples Enacted in 1782. Lawrence F. Flick, M.D., Sanitarium, N. Y., Vol. 26, 1891.
2. Pathological Researches on Phthisis—By P. Ch. A. Louis. Hilliard, Gray & Co., Boston, 1836.
3. A Brief and Intelligible View of the Nature, Origin and Cure of Tubercular or Scrofulous Disease. John Fondev, M.D. W. C. & J. Neff, Philadelphia, 1885.

"A Brief and Intelligible View of the *Nature, Origin, and Cure of Tubercular or Scrofulous Disease*, illustrated by Numerous Cases, Including, also, a Manual for the Application of Electro-Magnetism in this Disorder, by John Fonday, M.D., Professor of Theory and Practice of Medicine and Pathology in the Eclectic Medical College of Pennsylvania."

Skipping to chapter four, which is entitled "Cause of Tubercular and Scrofulous Disease", the first paragraph is as follows:

"As we design to make this work practical in its character, and intend to fit it not only for the use, as a manual of the physician, but also as a vehicle of information on the subject of tubercular disease to the non-professional reader, the individual who will need its aid for the removal of his disorders; we propose to consider its causes, noticing at least some which exert, as we conceive, a great influence in its production. Among these are inattention to the laws of diet; uncleanness; excessive indulgence of the passions; secret vice; depressing mental emotions; over-exertion of the body or mind; severe and protracted study; damp, unhealthy, foul habitations; illy ventilated rooms; mercury, blood-letting; profuse natural or artificial discharges; vaccination; severe disease, etc.; these, together with the action of cold, are among the most common causes which are productive of it."

Then the eminent gentleman continues to elaborate on a few of the points listed:

Blood-letting. A common cause of this disease is *blood-letting*. This was formerly employed to a much greater extent than at the present day, and has laid the foundation of an immense amount of tubercular disorder!

Vaccination. This is another of the grand causes of the disease which is under consideration. The time has not yet arrived for medical men to endorse the views which, as an individual (I do not wish to make eclecticism, nor the Eclectic Medical College of Pennsylvania, responsible for the correctness of these opinions: they are private views of my own), I entertain respecting vaccination, regarded as a preventive of smallpox; the time will yet come, however, I firmly believe, when men will wonder that they ever entertained the delusive idea, that independent of the protection which the *belief* that, they were thus protected, conferred upon them, vaccination should ever have been regarded as a boon granted to humanity. I do not propose in this place, nor in this work, to give my reasons for the opinion just expressed. My object in this volume is to point out the injurious results which not infrequently flow from vaccination. Much of tubercula or scrofula is, I conceive, due to this cause!

Mercury: This mineral is another powerful agent in the production of tubercula or scrofula. It seems as if for centuries medical men, like lunatics, have been running wild, casting firebrands, arrows, and

death. Scarcely a weapon could have been placed in their hands, by the Genius of Evil, which could have lent him more efficient aid in his work of destruction than the one which we are at present considering. The consequences, the deplorable consequences arising from the administration of this remedy, are sad and melancholy in their character. No honest and enlightened physician can shut his eyes to the fact of its destructive operation on the human organism; no physician ought to rest satisfied until he has found a substitute for the use of this corroding, devastating poison.

Time forces me to skip over much of this interesting volume, to page 210, which I thought would be illuminating to some of us who are interested in some of the present-day problems of medical economics and ethics. Under a large heading entitled *Medical Card*, we find the following:

For the treatment of that description of disease (as well as other diseases which come under the care of the physician) which constitutes the subject of this work; an affection so extensively prevalent, and involving often so many organs of the body; one to which his attention has for the last eleven years been directed; the subscriber may be consulted at his residence, or by letter (post-paid, containing a full history of the case), where the patient is, through disease, or distance, not able personally to visit him.

In such cases, the remedies which may be necessary, can be transmitted to the invalid by letter, or package, through the post office. With the facilities afforded by the mails, distance interposes no serious barrier to the transmission either of ideas or remedies.

Medical examinations, by means of the Eclectic Tests, will be made of the Lungs, Heart, Liver, Womb, and other organs; through these, an individual can be made personally sensible, and with great certainty also, of the existence of tubercular disease in his system.

Now, omitting a page or so of interesting reading we come to the summary of this part of the book:

As has been stated in the body of this work, the machines employed by me in the treatment of disease, are made by Messrs. W. C. & J. Neff, at 3½ South Seventh Street, Philadelphia. The middle size, price ten dollars, is the one which I usually employ. These machines, where desired, I can select and send (on the receipt of the money), by express or otherwise, to any part of the United States. Agents, of course, will apply directly, in all cases, to the Messrs. Neff.

JOHN FONDEY, M.D.

20 Logan Square, Philadelphia, Pa

The last four pages are given over to a listing of the Faculty of the Eclectic Medical College, and a biographic sketch of each member. It would appear that the author wrote them all, including his own, which is about six times as long as any of the others. I quote that portion which concerns the author, who was the Dean of the School. The italics and parenthetical remarks are most interesting. They are unchanged from the original volume.

The chair occupied by Dr. Fondey, is that of Theory and Practice of Medicine and Pathology. His efforts in this department will be directed to developing the true idea of Eclecticism; not confining himself to any one exclusive system of practice, but presenting the subject in a broad light, showing the union and intimate relation existing between the different systems; and that Allopathy, Homoeopathy, Hydropathy, Chrono-Thermalism, Botany, and Electro-magnethy, no matter how widely differing, apparently, in character, may all be used by the Eclectic in the treatment of disease; care being taken, however, to discard whatever is injurious, and retain whatever is good; the importance of avoiding the use of all remedies and processes which have a tendency to weaken the vital energies, and disorganize the human structure, being brought to bear upon the reason and conscience of the student, in a manner calculated to influence him to right action in practice.

The subject of tubercular disease will, as a part of the course of lectures delivered by him, be fully unfolded; and the student be thoroughly instructed in the method of preparing those remedies, which exert, apparently, a specific action in the treatment of this disorder.

The advantages which Philadelphia affords to the student of medicine, for a thorough qualification for his work, are unsurpassed by any city on the continent; the Hospitals, which are of the finest character, being accessible on the same terms to the students of all medical institutions.

Terms for Lectures:

- | | |
|---|---------|
| 1. The Matriculating Fee (paid on first session) | \$ 5.00 |
| 2. Course of Lectures (six professors, \$12 each) | 72.00 |
| 3. Fee for Graduation (Diploma) | 25.00 |
| 4. Demonstrator's Fee | 5.00 |

Terms Cash. In very peculiar circumstances of inability, on the part of the student, to pay the full amount in cash for Lecture Tickets (but *only* in such extraordinary cases), a well-endorsed note will be received for a small part of the amount, the remainder being cash.

Students on coming to the city will call on the Dean at his residence. For further information, special or otherwise, respecting the business of the College, etc., a line may be addressed (post paid) to

JOHN FONDEY, M.D., DEAN

20 Logan Square, Vine Street, Phila., Pa.

The next little treatise is by Horace Dobell, M.D.,⁴ on the "Nature, Cause and Treatment of Tuberculosis" and was published in 1866. It is an interesting work in which the Doctor advances with great enthusiasm *pancreatic dysfunction* as a cause of tuberculosis.

In 1874, Trudeau withdrew into the wilds of the Adirondacks eight years before the demonstration of the tubercle bacilli by Koch. Of his contribution to the tuberculous individual I need not refer in a meeting like this. To do so would be on a par with presenting a brief to a meeting of Methodist Ministers for the Man who wore a crown of thorns and carried a cross up a stony hill at Calvary about 2,000 years ago.

Next came Koch's world-shaking work—"Etiology of Tuberculosis" in 1882.

Twenty years later in 1903, Norman Bridge,⁵ Emeritus Professor of Medicine at Rush Medical College, published a book entitled "Tuberculosis". Sanity (as we see it now) was being established in phthiology. His opening paragraph is as follows:

Tuberculosis is the most frequent and destructive disease of man. It attacks many organs and appears in many forms,—forms that have been regarded as distinct diseases and known by a variety of names; and it destroys probably at least one-ninth of all the white races. It is now known to be due to the growth in the tissues of the tubercle bacillus, discovered by Koch in 1882; and no tuberculous lesion exists without the presence of this organism or of the direct influence of its growth and development.

On pages 228 and 229 are reproductions of the author's jackets for reducing the motion of one side of the chest. Journals of the A. M. A. are carrying advertisements for belts of a similar nature and purpose.

On January 1, 1905, there were in the State of New Jersey only two agencies formally interested in tuberculosis. They were the New Jersey State Commission in Regard to a Sanitarium; and the Anti-tuberculosis Campaign of the Oranges.

4. On the Nature, Cause and Treatment of Tuberculosis, Horace Dobell, M.D. John Churchill & Sons, London, 1866.

5. Tuberculosis—Norman Bridge, M.D. W. B. Saunders & Co., Philadelphia, 1903.

MODERN ATTITUDES

Present-day text books are, we hope, scientific, but they certainly lack the color of the works of yesteryear. It is just about the same, I suppose, as the colorless perfection of Jimmy Foxx at first base as compared with the free-swinging antics of Casey at the bat.

Monumental advances have been made in the treatment of the advanced cases, with our surgery, pneumothorax, etc. But is this after all an accomplishment to boast of? Are we as well informed as Louis? Do we accomplish any more than, or as much, for our patients as Trudeau did for his, seventy years ago? Has the brilliance of surgery's spectacular, but infrequent, accomplishments in salvaging previously admitted losses blinded us to the opportunities and responsibilities of the millions of potential tuberculous individuals? Might not the enthusiasm for the new, for the spectacular, lull us into a dangerous complacency? I would say, yes, if it were left to Doctors of Medicine alone. Not that they are selfish, or not anxious to improve the public health; but they are bound by traditions and ethics, a native reluctance for the spotlight, an inherent desire for anonymity, and a wish to avoid the inevitable public discussion that involves the civic-minded citizen.

MODERN PIONEERS

How then has this White Plague been slowed down so that now we have 60 deaths per 100,000, as compared to 200 per 100,000 in 1900, when it was said half the civilized adult population died of consumption? Ultimately, through the art and science of the twentieth century physicians, of course, but primarily through the work of a few. Of that few the majority were laymen, who at first braved abuse, and later received public acclaim. They forced through unpopular tenement legislation, compensation and sanitary laws, and at first puny appropriations for feeble departments of health. To the shame of the medical profession, it is often still the laymen who initiate needed reforms in many public health measures.

6. *Consumption and Civilization*. J. B. Huber, M.D. J. B. Lippincott, Philadelphia, 1906.

"Whilst meager phthisis gives a silent blow:
Her strokes are sure, but her advances slow.
No loud alarms nor fierce assaults are shown.
She starves the fortress first, then takes the town."
—Garth.

SOME FAMOUS VICTIMS

One becomes depressed as he contemplates the long death-roll of those of the world's great men and women who have succumbed to the tubercle bacillus. Had it not been for this organism, Bastien le Page might have given us another Joan of Arc to feast our eyes upon. Rachel might for many years have continued to permeate the spirits of her audiences with the divine fire that was in her. Botticelli in his *Venus* faithfully, if unintentionally, reproduced the sunken cheek, slender neck, sloping shoulders of his tuberculous model, Simonetta Catanea. Our Navy did well enough in 1812; but what a rip-roaring time there would have been if John Paul Jones had lived to take a hand in it. We might be reading more of Stephen Crane's stories. We might have had more of Robert Louis Stevenson's fascinating works. Schiller might have given us another "Song of the Bells". We might have taken another "Sentimental Journey" with Laurence Sterne. John Keats might have given us another "Endymion". Had the tubercle bacillus permitted, Nevin might have vouchsafed us another "Rosary", and Chopin another "First Polonaise". Lannec, who died of tuberculosis in 1826, might have continued his exhaustive study of the subject.

This bacillus is so minute that it was reserved for Koch, within the lifetime of at least two in this room, with the aid of an exquisitely high-powered microscope, to discover it.

Of all death-dealing agencies, Koch's bacillus has claimed the greatest number of victims. Tuberculosis has probably been co-existent with human existence, and very likely has affected our primordial ancestors.

INFLUENCE OF MIND OVER MATTER

"What's mind? No matter. What's matter? Never mind. What's spirit? It is immaterial." This, says Huber,⁶ is Punch's system of philosophy, and certainly there is none more uncontrovertible.

The manner in which the mind influences the body is as old a controversy as the nature of the mind itself. It is essential, notably in the tuberculous, that the influence of the mind upon the body be given a proper place in our reasoning. Mental strains derange the functions of various organs.

Psychology in tuberculosis is practically similar to that which obtains in every disease of long duration. Each of us must have observed, with sadness, stable, manly, engaging and lovable temperaments during a prolonged sickness, especially if return to health seems unlikely. Such changes are well typified in some dispositions which become altered during the period of senescence. There is no better example of this than Conan Doyle's sketch of Corporal Gregory Brewster in "Waterloo",—how the old man, who had in his youth done an act of splendid courage, and who had been an example of manliness in his prime, whined fretfully to be fed, cried like a child when his pipe fell from his hand, and was broken, and exulted that "Brother George never had such a pipe" when a new one was presented him. Upon awakening from dreamy sleep, however, he lived again for a moment that thrilling act of courage done in his youth, throwing back his bent shoulders, his emaciated form erect, his eyes flashing fire, shouting with a voice once again resonant: "The guards want powder, the guards want powder, and they shall have it"—and then falling back dead.

The pathetic fact seems to be, with regard to tuberculosis, perhaps more than in other conditions, that all phases of individual life, the physical, the moral, the mental, the spiritual, seem intimately blended and interdependent so that the whole is affected by an abnormality in any one aspect.

The tuberculous patient has to contend with some factors which do not generally hold in other chronic affections. He is sensitive, and his sensitiveness makes him morbid, when others around him manifest fear because of his mere presence among them; look upon him as if he had committed some crime; are annoyed because of the cough and the expectoration compelled by his disease.

The will of the tuberculous, as all other

mental aspects, is unstable and variable; there is sometimes an extraordinary optimism. The intellect is often acute; and sometimes, it is oddly uncanny. Elation, impulsiveness, obstinacy, irritability and hyperkinetic manifestations alternate with depression, a feeling of ego frustration, grief, disappointment because of non-improvement; fear and anxiety concerning their condition; mortification because of the attitude toward them of people in health; shock upon learning the disease from which they are suffering; home-sickness among those in sanatoria; religious gloom, and perhaps even terror.

TUBERCULOSIS AS A MODERN PROBLEM

The tuberculous individual is one of our major concerns. Tuberculosis still ranks number one in causes of death, during the most productive ages of fifteen to forty-five when it accounts for one-third, as compared to the general rate of one-seventh of all deaths. In a mild or severe form it still affects one-half of the human race. It kills twice as many as the automobile.

And why is this so? Because the front line of defense, quite properly the *general practitioner*, still is not thinking of tuberculosis as frequently as he should. Stewart¹⁰ quotes Punch as reporting two flappers discussing their medical advisers. One calls hers a *Pooh-pooh*. The other called hers a *Wind-upper*. The implications are obvious. The joint indictment is a sad commentary on too many of us.

We are still a long way from perfection in the diagnosis of early tuberculosis. In 1936-37, the Texas Tuberculous Sanatorium classified 3.9 per cent minimal; 79.6 per cent advanced; and 16.5 per cent non-tuberculous or childhood tuberculosis. This is paralleled by a well-known private institution with 10.6 per cent, 76 per cent and 13.4 per cent, so that this statistical experience is not restricted to tax-supported institutions. Sedar reported on 300 patients the total cost of whose care was \$261,780, which would have been \$139,790 or a saving of \$102,180 if admitted early. The responsibility is a dual one. Patients think the symptoms are

10. Stewart: *Journal of the Canadian Medical Ass'n*, April, 1928.

unimportant (71.7 per cent in one study delayed 3-24 months) and some physicians fail to make a careful study. They are the pooh-poohers.

Alexander⁹ brings the point very close to home when he says that the health problem of the Negro is the major health problem of any community where the Negro makes up a considerable percentage of the population. While tuberculosis as a cause of death in whites has dropped from first to seventh place, it has dropped only from first to second in the Negro. And, while the Negro makes up only five per cent of the national population, he accounts for 22 per cent of the mortality rate of the tuberculous.

RESPONSIBILITIES OF THE HOSPITAL STAFF

What, then, are our responsibilities? One responsibility is to reemphasize *early* diagnosis, and the *coöperation* of physician and patients to assure cures. We have not come a great distance from Trudeau in the management of the patients that offer the greatest opportunity of cure. Lawrason Brown⁷ gives four cardinal rules:

1. Rest,—physiological as well as physical. He points out that a severe cough may require as much energy in twenty-four hours as a long mountain climb.

2. Good food,—enough to attain or slightly exceed his optimum weight.

3. Fresh air—and of fresh air he wrote:

"The best medicine! Two miles of oxygen, three times a day. This is not only the best, but cheap and pleasant to take. It suits all ages and constitutions. It is patented by Infinite Wisdom; sealed with a signet divine. It cures cold feet, hot heads, pale faces, feeble lungs, and bad tempers. It has often been known to reconcile enemies, settle matrimonial quarrels, and bring reluctant parties to the state of double-blessedness. This medicine never fails. Spurious compounds are found in large towns; but get into the country lanes, among green fields,

or on the mountain top, and you have it in perfection as prepared in the great laboratory of Nature."

These three (rest,—good food,—fresh air) were formerly reversed, and the "rest" was slurred over, or hyphenated to properly regulated exercise. A fourth has been added—*Education*, to prevent a relapse.

If it is true that as Sophocles says, "The Gods always throw the dice impartially", and as Pottenger says—"While we must recognize the brand which is put upon us at birth by heredity, nevertheless most of the ills of life are due to environment", then our responsibilities are to admit that medicine is a *social* science as well as a *natural* science. We must lend the weight of our influence to make available for all people not only the unexcelled art and science of American Medicine, but also the other requirements of a *life abundant*.

Oliver Wendell Holmes said:

"God lent his creatures light and air
And waters open to the skies;
Man locks him in a stifling air
And wonders why his brother dies."

We have responsibilities as *citizens* as well as physicians.

PINE REST

The opening of the new Pine Rest should not mark the accomplishment of a goal, but rather the dawning of an era.

In this new building let us dispense, to the limit of our ability, the 1941 brand of the art and science of American Medicine that needs bend the knee to no era in any country. Let us fortify it with an equal part of the humanics of our medical forebears, to the end that Jew and Christian, Negro and white, of Atlantic County will say with Voltaire:

"Nothing is more enviable in life than a physician who, having studied nature from his youth, knows the properties of the human body and the diseases which assail it, exercises his art with caution; and pays equal attention to rich and poor alike."

7. Rules for Recovery from Pulmonary Tuberculosis. Lawrason Brown, M.D. Lea & Febiger, Philadelphia, 1934.

8. Diagnosis and Treatment of Tuberculosis. C. K. Koerth, M.D.; H. P. Thomas, M.D.; J. M. Donaldson, Jr., M.D. Diseases of the Chest, Vol. 11:1, January, 1941.

9. The Negro Health Program. Walter G. Alexander, M.D. Public Health News, December, 1940.

THE SURGICAL TREATMENT OF PEPTIC ULCER

By THOMAS A. SHALLOW, M.D., Philadelphia, Pa.

Professor of Surgery, Jefferson Medical College

Read before the Section on Surgery of the Annual Meeting of The Medical Society of New Jersey,
June 5, 1940.

One cannot discuss the surgical treatment of peptic ulcer *ex cathedra*. Every patient is a law unto himself. The decision to recommend surgical treatment must be reached only after proper evaluation is given to the benefits, the failures, or the complications which may follow this form of therapy.

As in many other pathologic lesions, we are handicapped by a lack of knowledge with regard to the etiology of peptic ulcer. It is true that many theories have been advanced in an attempt to give us the causes of the ulceration; but up to the present time, no one theory has been accepted as the causative agent of all ulcers. Until this information is available, one must view this lesion broadly. Were we fortified with definite information concerning its etiology, we could approach the problem of surgery more dogmatically.

You have heard this lesion discussed from the viewpoint of the gastro-enterologist, and several facts stand out preëminently—hyper-acidity, hyper-motility of the stomach, focal infection, the mental make-up of the individual, and his habits.

HYPER-ACIDITY FROM THE SURGEON'S VIEWPOINT

We have attempted to classify hyper-acidity into (a) primary hyper-acidity and (b) secondary hyper-acidity. In the former, or primary hyper-acidity, we accept the etiological factor as being some nerve imbalance between the sympathetic and the cerebro-spinal system. In this group, the mental make-up of the individual possibly plays the leading rôle. In order to separate this form of hyper-acidity from secondary hyper-acidity, we shall classify it as of undetermined origin.

Secondary hyper-acidity we believe to be due to focal infection, particularly from some adjacent structure, notably the gall-bladder, the liver ducts, the pancreas, or, lastly, the

appendix. One need only recall the words of Sir Berkeley Moynihan: "The stomach is so sensitive an organ that it cannot refrain from weeping when its neighbors are in trouble; and its voice is sometimes so loud as to drown that of the real sufferer", to have the importance of secondary hyper-acidity indelibly imprinted on his mind.

Do the medical men and the surgeons give this phase of hyper-acidity a sufficiently important position in treating peptic ulcer? It is my opinion that this is not adequately considered. It is not my purpose, however, to claim the existence of primary hyper-acidity, or to magnify the importance of secondary hyper-acidity, except to attempt an explanation as to why hyper-acidity in peptic ulcer continues to exist, and to recur during the course of medical treatment, and to recur when adequate surgical treatment is not performed. I am not going to claim that the treatment of peptic ulcer is the removal of the gall-bladder, the appendix, and the acid-producing portion of the stomach in the uncomplicated case of peptic ulcer; yet I wish to call to your attention the need for study of these various structures and the associated treatment required in patients who have infection of these structures.

We all know that peptic ulcer is a common lesion, that many of the ulcers heal spontaneously, and that most of them will heal under a strict medical regime. This latter subject you have heard discussed by my distinguished colleague, Dr. Lyon. He has emphasized the importance of rest, medical treatment, mental tranquility and the avoidance of alcohol and tobacco. For economic and sociologic reasons, this ideal plan of treatment is not available to many patients, so that medical treatment frequently fails to result in healing of the ulcer. The ulcer may recur or become chronic, and the complications of ulcer are prone to develop.

It is of these complications that we speak from the surgeon's viewpoint. We believe that these complications arise because of lack of knowledge of the etiology, the disregard for the contributing causes of hyper-acidity, failure to recognize atypical cases, together with the economic status of the patient.

What are the complications which require surgical consideration? Hemorrhage, perforations of the acute, subacute and chronic types, pyloric obstruction, and the development of malignancy as a complication to gastric ulcer. Then, too, we have the problems arising from the failures of surgery—particularly recurrent duodenal ulceration and marginal ulcer.

HEMORRHAGE

In discussing hemorrhage as a complication, the distinction as to the site of ulcer must be definitely made. Bleeding from a gastric ulcer should be viewed with more than the remote possibility of an early carcinoma. The importance of this possibility should be considered more than the amount of blood lost.

Bleeding from a duodenal ulcer must be viewed through the surgeon's eyes, depending upon the site of the ulcer,—that is, whether it be on the anterior or posterior wall. We do not view the former, the ulcers on the anterior wall, especially in the young—even with severe hemorrhage,—as a serious problem. The origin of the hemorrhage is usually from vascular buds of granulation tissue, or from a small vessel. Because of the age of the individual, blood loss is easily overcome and because of the ulcer site, with the absence of large vessels in this area and the contractibility of the elastic coats of the vessels in youth, this hemorrhage is readily controlled medically.

On the other hand, ulcers on the posterior wall of the duodenum which recur, even though they be in the young, deserve serious consideration. The hemorrhage results from an erosion of the pancreaticoduodenal artery or one of its branches. Irrespective of the age of the patient, posterior ulcer bleeding is a serious problem, and in individuals approaching the fifties, such hemorrhages demand surgical intervention.

WHEN TO OPERATE

Most surgeons agree that surgery should not be instituted during the period of active bleeding, except in the rare case when the bleeding is gravely menacing the life of the individual.

Gordon Taylor, in the *British Journal of Surgery*, has well expressed the subject of prognosis and the significance of active continuous bleeding in peptic ulcer. I should like to summarize his words as follows: Of patients who bleed on the first day and stop, 80 per cent will survive for more than eight days, and 60 per cent will live fourteen days or more. This is a broad statement because it does not break down the 60 per cent into those with recurrent hemorrhages immediately after this period. It warns us, however, that there may be recurrence in 60 per cent of all patients with chronic peptic ulcer when they have had one frank hemorrhage.

When the individual bleeds for two consecutive days and stops, he is much better off than those who bleed the first day, stop, and bleed the third day. This, to my mind, is an indication of a large vessel which has not been controlled; and Taylor states that there is an 80 per cent mortality in this group, and they usually die within the next two days.

It is the accepted opinion of most surgeons that the critical period of hemorrhage is on the third day. We have therefore to consider a life-saving procedure which has for its aim the control of the bleeding point. Most of these bleeding ulcers are on the posterior wall of the duodenum or of the lesser curvature of the stomach; and we have a choice between the direct approach to the ulcer bed by the transduodenal or trans-gastric route, or the ligation of the blood supply to the part involved—in the duodenum, the gastro-duodenal artery.

According to the statistics of Taylor, he has had remarkable success in this procedure, having successfully controlled the bleeding through these routes in nine out of eleven attempts, in the acute duodenal ulcer. He gives statistics to show that between 1919 and 1937 the operation had been performed on 82 occasions with 72 recoveries.

It has been shown that the incidence of hem-

orrhage of the severe type in chronic peptic ulcer is 10 to 12 per cent. Most of these hemorrhages occur from ulcers on the posterior wall. The incidence of hemorrhage of a milder degree is from 20 to 30 per cent; and they do not interest us particularly as surgeons but call for more care and supervision on the part of the medical men.

SURGICAL PROCEDURE

The surgical procedure should be limited to that group of patients in whom the ulceration has been severe, due consideration being given to the age of the patient and the amount of the bleeding. It is our policy to recommend surgery when any of the hemorrhages, whether the first or a later one, produces a fall in the hemoglobin below 50 per cent and in the red blood cell count below two million—even though the individual is relatively young.

When hemorrhage occurs in patients over the age of forty, one severe hemorrhage indicates that radical surgery is necessary. These views are expressed more or less dogmatically, even though we recognize that after radical surgery there may be a recurrence of the ulcer and hemorrhage. In hemorrhage, however, we are faced with definite facts which must be weighed against the risk of possibility; and we should therefore perfect our surgical technic and select an operation which gives the minimal amount of jejunal trauma and insist on the subsequent medical control of the patient in follow-up clinics.

PERFORATIONS

Perforation is by far the most serious emergency we are called upon to combat in peptic ulcer. Frequently this requires very little exercise of our intelligence; but when one realizes that about 20 per cent of all cases which perforate do not present any symptoms which would lead us to suspect the presence of a peptic ulcer, and that 15 per cent in addition to the 20 per cent present atypical symptoms, the diagnosis of perforated peptic ulcer is frequently missed or confused with a less serious abdominal lesion.

It is not my purpose to go into the sympto-

matology of the acute perforation because this is a matter well known to all of you; but I should like to call to your attention the value of scout x-ray films in reaching a diagnosis in questionable cases. It has been our experience that more than 95 per cent of perforations can be picked up by the roentgenologist. This fact, in our opinion, is of great importance because of the prognosis of this disorder when considered from the standpoint of time elapsing between perforation and operation.

John McCreery, in his recent article, has given the statistics of the Bellevue Hospital concerning the time element from the standpoint of prognosis. These figures are almost identical with our findings. He shows definitely that the highest mortality percentage—80 per cent—occurs between the twenty-fourth and the forty-eighth hour. He further shows that after the forty-eighth hour the percentage of mortality falls to 60, and that in those individuals who had not been operated upon, the mortality rate fell to 37.5 per cent. This should give us something to think about, and make us wonder whether the prognosis would not be better if no one was operated upon after the forty-eighth hour unless localization had occurred. It is true that in many cases localization would not occur and the individual would die of a septic peritonitis; but from these statistics and our experience we believe that a greater percentage of recoveries would result by the expectant watchful-waiting method, rather than by surgical intervention. Then, when the abscess developed, drainage should be instituted. It is our opinion, when the secondary abscess period is awaited; that no attempt be made to find the ulcer, repair it or do any other form of surgery.

The question of surgical procedure in acute perforation has varied in our clinic. We have finally reached the conclusion that simple closure of the perforation—whether that be gastric or duodenal—is sufficient for the primary operation. Our statistics do not show that in those individuals upon whom gastro-enterostomy was added to this procedure, the results were any better, and in no case in acute perforation do we perform a partial gastrectomy.

Concerning drainage. Much dispute has arisen concerning the necessity for drainage, but we dogmatically take the attitude that drainage should be instituted in the supra-pubic area and not at the site of the perforation. Supra-pubic drainage is always instituted, and the upper abdominal wound is closed without drainage.

Subacute perforations into the body of the pancreas—whether they be gastric or duodenal—are treated by subtotal gastric resection. Perforations into the protected area and margins of the gastro-hepatic omentum usually produce local abscess. These, if recognized in their early hours, are immediately operated upon, the ulcer closed, and drainage instituted at the site of the abscess. When these cases are not observed until after eighteen hours and there is no evidence of spreading peritonitis manifested by spreading rigidity, increase in pain and rise in leucocyte count, then the conservative plan is followed and localization is awaited.

PYLORIC OBSTRUCTION

Very frequently there is much uncertainty as to the degree of pyloric obstruction. This, of course, is understandable when one considers the influence of spasm in conjunction with the contraction of a healed or a healing ulcer; and it is this element of spasm which must be eliminated before a conclusion can be reached as to the degree and the amount of obstruction. It is therefore necessary not to reach a conclusion on one x-ray film as to the degree of obstruction. Several should be made. It has frequently been observed by us that a 50 per cent gastric obstruction in six hours will vary considerably from day to day; and unless there is constant 50 per cent gastric retention in six hours and some retention at the end of twenty-four hours, gastro-enterostomy should not be done, but some form of gastric surgery should supplant this procedure. This is entirely opposite to the previous teaching of Moynihan and other older surgeons of equal rank; but the conclusion is borne out by our observations and those made in New York at the Presbyterian Hospital by St. John, Harvey, Gius, and Goodman. In their excellent

article standardizing the pathologic results which led up to the operative procedure in that institution over a period of nineteen years, they proved conclusively that gastro-enterostomy had a place in the treatment of persistent obstruction; but that the statistics published by them did not warrant this procedure in any other complication of peptic ulcer. In all other forms of obstruction, except the persistent 50 per cent retention, whether that be gastric or duodenal ulcer, partial gastrectomy should be done.

It has been our policy to use the Polya procedure in all of our cases. The above authors show that equal success can be obtained by the Bilioth II procedure.

MALIGNANCY AS A COMPLICATION TO PEPTIC ULCER

Malignancy as a complication of peptic ulcer is one of the rarities in duodenal ulcer; but arises in from eight to twelve per cent of all cases of gastric ulcer. Malignancy should be suspected when the gastroscopic examinations or x-ray reveals a large ulcer, or one that is spreading in circumference. We should therefore anticipate malignancy in all chronic gastric ulcers, and institute radical procedure in the form of partial gastrectomy in all peptic ulcers of the stomach which do not rapidly respond to medical measures. It is in this group that we have had our best results.

THE FAILURES OF SURGERY

Little need be said about the permanent effects of surgery in the treatment of peptic ulcer. The occurrence of jejunal ulcer and its complications are all too frequent. Likewise the recurrence of ulcer and ulcer symptoms, even after the best approved surgical and medical measures have been carried out, is apt to prove disappointing. Jejunal ulcer has occurred in 3.5 per cent of a series of 6,402 patients operated upon in the Mayo Clinic. In another series of 1,000 patients subjected to gastro-enterostomy, thirty-five required further surgery. This complication is seen also following sub-total gastrectomy. Statistics here avail us little, for few series have been followed over a long enough period to be worth while. Jeju-

nal ulcer, however, is known to occur more frequently in patients who present a hyperacidity with little gastric retention. For this group we have already advised a sub-total gastric resection.

The complications of jejunal ulcer are hemorrhage, perforation—acute, subacute or chronic, and jejuno-colic or gastro-jejuno-colic fistula.

Hemorrhage is the most frequent complication; and when bleeding occurs from a jejunal ulcer, then further surgery is indicated.

Perforations of jejunal ulcers must be handled as are those of peptic ulcers elsewhere. Usually, however, a secondary operative procedure is required to care for the ulcer if the immediate dangers are survived.

Operative procedures as curative measures for jejunal ulcers cannot be by further short-

circuiting operations. If the ulcer has followed a previous gastro-enterostomy, then sub-total gastrectomy with excision of the ulcer is advisable. Should jejunal ulcer follow sub-total gastrectomy, then a more radical gastric resection must be performed.

Jejuno-colic and gastro-jejuno-colic fistulae are indeed grave complications. Any attempted operation is fraught with serious risk. These poorly nourished patients have to be carefully handled. Be the fistula a small one, closure of the colonic opening, with a reestablishment of the gastro-intestinal tract by undoing the gastro-enterostomy, is indicated. In larger fistulae, multi-stage operations of various types are indicated. These combining sub-total gastrectomy, when the patient is in condition to withstand it, hold great promise of cure.

1611 Spruce Street

TREATMENT OF GASTRIC ULCER

British physicians find that the emotional strain of the war has greatly increased the incidence of gastric ulcer. It has been necessary to work out swift and safe methods for treating these new ulcer patients, not only for the purpose of restoring the soldier to his position and the civilian worker to his factory, but also for the purpose of conserving hospital beds. A recent report in the *Practitioner* describes their treatment method.

Long-standing cases of stomach ulcer which had not responded to medical treatment in the past or patients who have had relapses were subjected to immediate operation. Those who were considered suitable for medical treatment were confined to bed for two weeks and placed on a diet of soup, milk, fish, eggs, butter, bread, jelly, and custard—a diet that was di-

vided into six feedings daily. Olive oil and magnesium trisilicate were employed as antacids, and phenobarbital was administered to allay nervousness. The patient was forbidden to smoke. Under this regimen, with gradual additions to the diet, half of the patients were able to return to full-time work in from four to twelve weeks. Following this, the employers were instructed to give these men sufficient time off for frequent meals and lunches. Among the others who did not do well on the home treatment, it was found that family cares and the difficulties encountered in nursing and in dietetics were the principal factors acting as deterrents to medical treatment. These patients were then promptly hospitalized.

If this works so well on the eastern shore of the Atlantic Ocean, one wonders if it would not be worth trying on this side of the water.

RHINOSCLEROMA IN NEW JERSEY WITH CASE REPORT

HENRY Z. GOLDSTEIN, M.D., Newark, N. J.

EXAMINATION

Rhinoscleroma is an uncommon, chronic, granulomatous disease affecting the mucosa of the upper respiratory tract, especially the nose, nasopharynx, pharynx, and larynx. This disease is supposedly caused by the bacillus of Frisch and is accompanied by a characteristic pathologic picture. At first a granulomatous disease, rhinoscleroma gradually produces a firm scar tissue covered with crusts, without any tendency to ulcerate. It sets up all grades of obstructive symptoms depending on the degree of infiltration, site of the scar tissue and extent of the disease.

A careful search of the literature in the United States for the last 50 years reveals 66 cases of rhinoscleroma. Eight of the patients were native born and 58 foreign born. Of these, two cases were reported from New Jersey; one by G. B. Wood in a native American and one by C. Gadomski in a foreign-born patient. While rhinoscleroma is fairly common in Russia, Poland and Austria, it is rare in the United States and especially uncommon in New Jersey where only two cases have ever been reported.

To this rather small list I should like to add another case of rhinoscleroma in a foreign-born resident of New Jersey.

CASE REPORT

Mrs. E. D., aged 50, white, born in Austria, first came to the Nose and Throat Clinic of the Newark Beth Israel Hospital in June, 1940, complaining of marked nasal obstruction, nasal crusting and hoarseness. She had come to this country at the age of 12. She was perfectly well until ten years ago when she began to suffer from nasal obstruction and nasal dryness which gradually became worse. She went from clinic to clinic and was treated for "sinusitis" and "dry nasal catarrh". She steadily grew worse and four years ago she became hoarse. This has become more severe, and at present she speaks with a low raucous tone. Lately she has become slightly dyspneic. No one in her immediate family has had any nasal trouble.

The patient was an obese, white woman with a markedly hoarse voice. The base of the nose seemed slightly broadened, and the alae were thickened as was the columella. Both vestibules were almost completely stenosed with a hard, cartilaginous type of tissue covered with mucus and crusts. After removal of the crusts, the stenosis was seen to be caused by a hard, firm layer of tissue which extended back to the nasopharynx. The nasal stenosis was almost complete, admitting a small catheter only. In the nasopharynx were red, hard, granulomatous masses which bled rather easily. There were no ulcerations. Neither the pharynx nor epiglottis were involved. Both cords showed impaired motility. There were large, pale, firm, granulomatous masses obscuring the upper portions of both vocal cords extending across the anterior commissure. There was no extension below the cords, and breathing space appeared to be ample.

The eardrums showed retraction. The patient displayed some impairment in hearing lower tones.

In July, 1940, a biopsy was taken from the nose and from the larynx. Dr. William Antopol, pathologist at the Beth Israel Hospital in Newark, described the tissue as follows:

"Portions of nasal mucous membrane partly covered by high cylindrical, partly by squamous epithelium. The squamous epithelium is thin and pale, in places completely absent. Between the cells, particularly in the subepithelial layers, there are scattered polymorphonuclear leucocytes. The deeper areas contain broad bands of fibrous tissue, large nests of cells composed for the most part of plasma cells with some macrophages, round cells, fibroblasts and polymorphonuclear leucocytes. In addition, large round or oval cells with clear cytoplasm are found throughout the specimen. They measure 40-50 microns in diameter and have an eccentric, pale staining nucleus which may be round or oval. The cytoplasm is for the most part clear, but sometimes has a foamy appearance. The cells appear single or in small groups, though in certain areas they form large nests. A number of capillaries filled with blood are found between the cells. Occasional round eosinophilic bodies (Russell bodies) are seen.

"Diagnosis: Rhinoscleroma."

From the laryngeal biopsy a similar though less pronounced picture was seen.

Culture of biopsy material and from nasal washings revealed a growth of *Bacillus Rhinoscleromatis* from which a vaccine was prepared. Dr. Philip

X-RAY TREATMENTS

Date	Area	Filter	K.V.	M.A.	Dist.	Field	Time	Per Cent S.E.D.
8- 7-40	Left Larynx	$\frac{1}{2}$ cu l al	180	8	50 cm	10 by 15	2 $\frac{1}{4}$	50 "R"
8-13-40	" "	" " "	"	"	" "	" " "	"	" "
8-20-40	" "	" " "	"	"	" "	" " "	"	" "
8-30-40	" "	" " "	190	5	" "	8 by 10	2	" "
9-13-40	" "	" " "	"	"	" "	" " "	6 $\frac{1}{4}$	100 "R"
9-20-40	" "	" " "	"	"	" "	" " "	6 $\frac{1}{2}$	100 "R"

Date	Area	Filter	K.V.	M.A.	Dist.	Field	Time	Per Cent S.E.D.
8- 9-40	Right Larynx	$\frac{1}{2}$ cu l al	180	8	50 cm	10 by 15	2 $\frac{1}{4}$	50 "R"
8-16-40	" "	" " "	"	"	" "	" " "	"	" "
8-27-40	" "	" " "	190	5	" "	8 by 10	2	" "
9- 9-40	" "	" " "	"	"	" "	" " "	3	" "
9-16-40	" "	" " "	"	"	" "	" " "	6 $\frac{1}{4}$	100 "R"
9-24-40	" "	" " "	"	"	" "	" " "	6 $\frac{1}{2}$	100 "R"

Date	Area	Filter	K.V.	M.A.	Dist.	Field	Time	S.E.D.
9- 3-40	Right Nasopharynx	$\frac{1}{2}$ cu l al	190	5	50 cm	6 by 8	4	100 "r"
9- 9-40	" "	" " "	"	"	" "	" " "	6 $\frac{1}{4}$	" "
9-16-40	" "	" " "	"	"	" "	" " "	"	" "
9-24-40	" "	" " "	"	"	" "	" " "	6 $\frac{1}{2}$	" "
9- 3-40	Left Nasopharynx	" " "	"	"	50 cm	6 by 8	4	100 "r"
9-13-40	" "	" " "	"	"	" "	" " "	6 $\frac{1}{4}$	" "
9-20-40	" "	" " "	"	"	" "	" " "	6 $\frac{1}{2}$	" "

Levine, bacteriologist at the Newark Beth Israel Hospital, reported on it as follows:

"The organism isolated from the nasal discharge of this patient corresponds to that known as *Bacillus Rhinoscleromatis*. It possesses the following cultural characteristics:

"*Morphology*: Plump, short rod with rounded ends with a distinct capsule.

"*Colonies*: Round, convex, slimy.

"*Gelatin Stab*: Nail-like formation, no liquefaction.

"*Indol Formation*: Negative.

"*Dextrose Broth*: Acid, but no gas.

"*Litmus Milk*: No coagulation or peptisation.

"*Lactose Broth*: Very slight acid production."

A blood Wassermann was negative and x-rays of the sinuses revealed a slight cloudiness of the right ethmoid and right antrum. Irrigation of the right antrum returned a clear solution which did not grow *Bacillus Rhinoscleromatis*.

It was suggested that a combination of radiotherapy and autogenous vaccine would be the most effective method of treatment. Injections of autogenous vaccine were accordingly given twice a week starting with 0.01 c.c. and gradually increased to 1.0 c.c., which dose she is now receiving once a week.

The patient was then referred to Dr. L. Levinson of the Radiotherapy Department of the Newark Beth Israel Hospital, who administered the following treatment:

RADIUM TREATMENTS

Left Nares	Rad.	Filter	Dose	Time
7-10-40	15 mg.	1 mm. plt.	30 mghrs.	2 hrs.
7-31-40	" "	" " "	" "	" "
8- 9-40	" "	" " "	" "	" "
8-16-40	" "	" " "	" "	" "
8-27-40	" "	" " "	" "	" "

Total 150 mghrs.

Right Nares	Rad.	Filter	Dose	Time
7-17-40	15 mg.	1 mm. plt.	30 mghrs.	2 hrs.
7-24-40	" "	" " "	" "	" "
8- 7-40	" "	" " "	" "	" "
8-13-40	" "	" " "	" "	" "
8-20-40	" "	" " "	" "	" "
8-22-40	" "	" " "	" "	" "
8-30-40	" "	" " "	" "	" "

Total 210 mghrs.

On September 5, 1940, the stenosis of the nose was definitely less. Nasal breathing had improved. The masses in the nasopharynx had shrunk. The patient was more comfortable. The mass in the larynx seemed less. However, the hoarseness was marked. The slight dyspnea had cleared up.

On October 28, 1940, she was still improving. The nasal obstruction was markedly less although still crusting. There was no dyspnea, but the granular tissue was still present.

THE MEDICAL SOCIETY OF NEW JERSEY

FOURTH ANNUAL FALL CLINICAL CONFERENCE ELIZABETH, N. J.



Host: Union County Medical Society—Lorrimer Armstrong, M.D., President
Date: Wednesday, December 3, 1941.

MORNING

Select either Session A or Session B

Session A

8:30-9:30 A. M.—REGISTRATION at Elks' Club, 21 Westfield Avenue at Broad Street, Elizabeth.

9:30 A. M.—BUSES leave for INDUSTRIAL PLANTS, where luncheons will be served following the sessions. Select one of the following destinations:

Plant 1—Calco Chemical Company, Bound Brook, N. J.:
"Poisoning by Aniline and Similar Compounds."

Plant 2—General Aniline Chemical Co., Linden, N. J.:
"Some Phases and Fallacies Resultant from Lack of Coöperation by the Family Physician with his Colleague in Industry."

Plant 3—Graselli Chemical Co., Linden, N. J.:
"The Placement of Cardiac Patients in Industry with a Special Reference to Coronary Cases."

Plant 4—Merck & Co., Inc., Rahway, N. J. (in conjunction with DuPont Dye Works):
"Industrial Dermatoses and Drug Poisoning."

Plant 5—Standard Oil Company of New Jersey, Elizabeth, N. J.
"The Industrial Medical Department and the Family Doctor."

Plant 6—United States Metals, Carteret, N. J.:
"Lead in Industry—Its Hazards and Control."

Plant 7—Western Electric Company, Kearny, N. J.:
"Fatigue and Its Relation to Industrial Health."

For Session B, see next page.

FOURTH ANNUAL FALL CLINICAL CONFERENCE**December 3, 1941, Elizabeth, N. J.****Session B**

8:30-9:30 A. M.—REGISTRATION at Elizabeth General Hospital, 925 East Jersey Street.

9:30-12:30 P. M.—“Presentation of Cases from the Department of Malignant and Allied Diseases; Discussion of Diagnosis, Prognosis and Treatment.”

Drs. A. R. Casilli and W. O. Wuester.

Doctors attending this Session are invited to be the guests of the Society at a luncheon at the Elks' Club.

AFTERNOON

(Buses from industrial plants will return to Elks' Club)

Lodge Room of the Elks' Club, 21 Westfield Avenue

2:30-2:55 P. M.—Eye, Ear, Nose and Throat Section; Dr. E. P. Cardwell, Chairman.

“Tonsillectomy by Eversion and Snare.”

Henry C. Barkhorn, M.D., Newark.

Otologist to the Eye and Ear Infirmary

2:55-3:20 P. M.—Gastro-Enterologic Section; Dr. C. D. Smith, Chairman.

“Ulcer and Cancer of the Stomach, Through the Ages.”

H. I. Goldstein, M.D., Camden.

President of the New Jersey Gastro-Enterological Society

3:20-3:45 P. M.—Section on Medicine; Dr. D. W. Marquis, Chairman.

“Circulation Time and Venous Pressure: Procedure for the General Practitioner.”

E. C. Klein, Jr., M.D., Newark.

Attending Physician to the St. Barnabas Hospital

3:45 4:10 P. M.—Obstetrics and Gynecology Section; Dr. H. B. Wilson, Chairman.

“Ovarian Tumors Complicating Pregnancy.”

Robert A. MacKenzie, M.D., Asbury Park.

Director of Obstetrics at the Monmouth Memorial Hospital

4:10-4:35 P. M.—Pediatrics Section; Dr. Vincent Del Duca, Chairman.

“Breast Feeding, Its Uses, Production and Preservation.”

Albert Scott Harden, M.D., Maplewood.

Assistant Pediatrician to the Babies' Hospital

4:35-5:00 P. M.—Radiology Section; Dr. N. J. Furst, Chairman.

“Radiology in Obstetrics.”

H. J. Perlberg, M.D., Jersey City.

Radiologist to the Margaret Hague Maternity Hospital

5:00-5:25 P. M.—Surgery Section; Dr. C. A. Beling, Chairman.

“Compound Fractures.”

Elmer Peter Weigel, M.D., Plainfield.

Orthopedic Surgeon to the Muhlenberg Hospital

5:30-6:30 P. M.—Business meeting of the sections. Nominations and elections of section officers.

Alternate afternoon program on page opposite.

FOURTH ANNUAL FALL CLINICAL CONFERENCE

December 3, 1941



AFTERNOON

Spanish Room of Elks' Club

2:30-5:30 P. M.—Special program of scientific moving picture films.



EVENING

7:00 P. M.—Cocktails in the Elks' Club.

21 Westfield Avenue, near Broad Street, Elizabeth

7:30 P. M.—Informal Dinner in the Elks' Auditorium.

Tickets: \$2.

Toastmaster

Edward G. Bourns, M.D.

Speaker

Johannes Steel, distinguished radio commentator

Topic

World Conditions: A Realistic Appraisal

THE MEDICAL SOCIETY OF NEW JERSEY

FOURTH ANNUAL FALL CLINICAL CONFERENCE

Wednesday, December 3, 1941, Elizabeth, New Jersey

GENERAL CHAIRMAN

WATSON B. MORRIS, M.D., Springfield

HONORARY CHAIRMEN

WILLIAM E. BOOZAN, M.D., Elizabeth

GEORGE KNAUER, M.D., Elizabeth

M. A. SHANGLE, M.D., Elizabeth

ASSOCIATE CHAIRMEN

JAMES M. CARLISLE, M.D., Westfield, Chairman, Scientific and Industrial Hygiene Committee

GEORGE SEYMOUR, M.D., Elizabeth, First Vice-President, Union County Medical Society

PAUL KRUTZ, M.D., Elizabeth

WILLIAM C. MEINEKE, M.D., Roselle

ALBERT LEWIS, M.D., Cranford

FRED F. SENERCHIA, M.D., Elizabeth

PARKING

Three parking lots have been provided within one block of the Elks' Club. Policemen at the corner of Westfield Avenue and Broad Street or Westfield Avenue and Morris Avenue will direct members to the parking lots.

REGISTRATION

A registration desk will be maintained in the Elks' Club, 21 Westfield Avenue, Elizabeth, N. J., for those who are to take buses going to the industrial plants, and a registration desk will be at the Elizabeth General Hospital, East Jersey and Reid Streets, Elizabeth, N. J., for those attending the hospital presentation.

DINNER

At 7:30 p. m. at the Elks' Club, Wednesday evening, December 3rd, 1941 (cocktails at 7 p. m.). Informal. Tickets, \$2.00.

TELEPHONE

Telephone service will be maintained in the Elks' Club, ELizabeth 3-2400, and at the Elizabeth General Hospital, ELizabeth 2-3400.

RESERVATIONS

To expedite the program, members are urged to indicate in advance which sessions they are selecting and whether they are going to the dinner. Reservations should be sent to the Union County Medical Society, 1137 East Jersey Street, Elizabeth, N. J. If checks accompany reservations (\$2 per cover for the dinner) a dinner ticket and an automobile sticker for police courtesy privileges will be sent promptly to the member.

STATISTICS ON THE TOXEMIAS OF PREGNANCY AS A CAUSE OF MATERNAL MORTALITY IN NEW JERSEY MATERNAL WELFARE ARTICLE NUMBER SIXTY-FOUR

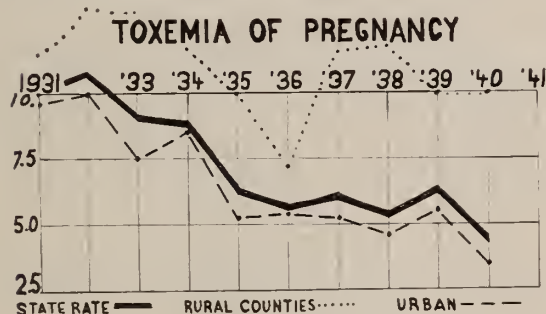
By ARTHUR W. BINGHAM, M.D., East Orange, N. J.

Chairman, Committee on Maternal Welfare of The Medical Society of New Jersey; and
Chief Advisory Obstetrician, Bureau of Maternal and Child Health,
State Department of Health.

This is the fourth article on New Jersey Maternal Mortality Statistics for 1940

Maternal mortality from toxemia reached the lowest rate in the history of New Jersey in 1940 when the figure was 4.2 per 10,000 live births. Yet in analyzing the deaths from puerperal sepsis we find that 33 per cent of these cases were also toxic. In 1930 the mortality rate for toxemia was 12 per 10,000 live births.

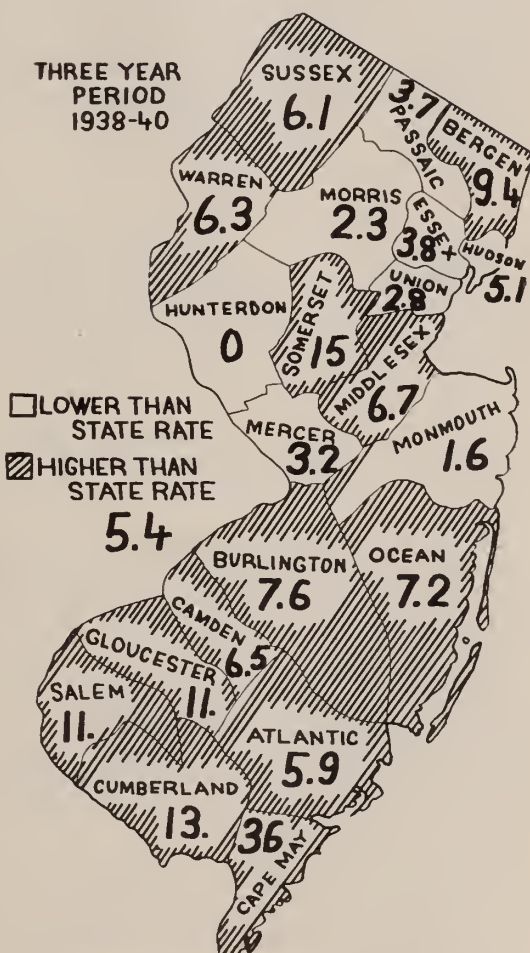
In 1940 eleven counties had rates below the State rate. These counties represented 25,251 live births with two deaths due to toxemia making an average rate of 0.7 per 10,000 live births for this group. The counties with rates above the State rate had 33,367 live births with 23 deaths making an average rate of 6.8 per 10,000 live births.



According to the State Department of Health, ten counties are classified as rural. Four of these had no death due to toxemia in 1940, yet the average rate for the rural counties was 10 per 10,000 (same as in 1939) compared with a rate of 3.4 for the urban counties (a decrease from 5.8 in 1939). According to these figures the improvement occurred in the urban counties taken as a group.

The map (Fig. 7) is prepared on a three-year basis as a fairer comparison of county rates as some rural counties have so few births annually.

TOXEMIA OF PREGNANCY



RATES ARE PER 10,000 LIVE BIRTHS

The graph (Fig. 17) shows the mortality rates for toxemia for a period of 10 years. The solid line is the State as a whole, the dotted line is the rural rate, and the dashes are rates for the urban counties.

There are usually about seven times as many

live births in the urban as in the rural counties. As a group, the patients in the urban counties have better facilities for receiving prenatal care than do those in rural areas.

In the group of toxemia deaths (25) were 22 white (rate 3.7) and 3 colored patients (rate 6.5). Primigravida 14, multigravida 7, and 4 histories did not state. Average age was 27 years.

There were 9 live births, including one set of twins, 6 stillbirths, two histories did not state which, and 9 cases were undelivered. The period of gestation varied from 1 case at 5 months, 2 at 6 months, 4 at 6½ months, 3 at 7 months, to 5 at 9 months. The average length of time from delivery to death was 3½ days, varying from 1 hour to 15 days.

UNDELIVERED CASES (9)

Ages ranged from 16 to 32 years. Five died of eclampsia; one albuminuria; one toxemia and psychosis; one hypertensive toxemia; one albuminuria, hypertension, and cerebral hemorrhage.

Case 31.—Primigravida. Gestation 8½ months. Prenatal care 2 months, but patient neglected it last month as her own physician was away. Eclampsia.

Case 34.—Primigravida. Gestation 7 months. City resident. No prenatal care. Obese. Not coöperative. Signed release from hospital against advice while being treated for toxemia. Readmitted next day. Eclampsia.

Case 36.—Primigravida. Gestation 5 months. Rural resident. One prenatal visit. Died while being prepared for induction. Toxemia, psychosis.

Case 54.—Primigravida. Gestation 8 months. Clinic patient. City resident. Died while being prepared for cesarean just after spinal had been administered. Hypertensive toxemia.

Case 55.—Primigravida. Gestation 6 months. No prenatal care. City resident. Eclampsia.

Case 112.—Primigravida. Gestation 6½ months. One prenatal visit. Town resident. Weight 211 pounds. Eclampsia.

Case 125.—Primigravida. Gestation 6½ months. Had prenatal care. Eclampsia.

Case 175.—Multigravida. Gestation 6½ months. Previous pregnancy resulted in toxemia and stillbirth at 6 months' gestation. One prenatal visit. Not coöperative. City resident. Albuminuria, hypertension, cerebral hemorrhage.

Case 177.—Multigravida. Gestation 8 months. Had had 4 children. Always refused prenatal care. Rural resident. Albuminuria.

ECLAMPSIA (13)

Five of these cases were not delivered. Of the remaining eight cases two were multigravida—ages 41 and 43 years.

The first case was in a rural resident who had had two visits to physician. She denied pregnancy. Her weight was 300 pounds. Gestation 7 months. Low forceps delivery. Macerated foetus. Died 26 hours post partum.

The second case was a city resident. Grav 6, para 5. No prenatal care. Gestation 8 months. Live baby. Normal delivery. Elevated temperature. Died 7 days post partum.

The ages of the six delivered primigravida ranged from 19 to 35 years.

Case 25.—Age 29. Gestation 9 months. One prenatal visit. Cesarean. Stillbirth. Ward pay patient. Died 24 hours post partum.

Case 50.—Age 19. Gestation 9 months. Had refused to see physician. Home delivery. Live baby. City resident. Died 2 days post partum.

Case 87.—Age 31. Gestation 7½ months. Prenatal case began in third month. Emergency cesarean. Private patient. Stillbirth. Patient died 1 hour p. p.

Case 119.—Age 20. Gestation 9 months. Prenatal care started at 7 months. Forceps delivery. Stillbirth. Died 3 hours p. p.

Case 133.—Age 35. Gestation 8 months. Prenatal care started at 2 months. Labor induced 3 times, castor oil and pitocin. Labor 4 hours. Normal delivery. Twins, live births. Patient died 5 days p. p.

Case 162.—Age 23. Gestation 7½ months. Prenatal care began in first month. Had had previous therapeutic abortion early in pregnancy because of toxemia. B. P. systolic 180 at 4 months. Low forceps delivery. Live baby. Convulsions began 4 hours after delivery. Patient died 10 hours p. p.

ALBUMINURIA (6)

In this group two multiparae died before delivery. These case histories are briefly outlined under Undelivered Cases.

Case 4.—Multigravida. Age 36. Gestation 7 months. No prenatal care. Stillbirth. Died 8 days p. p. Autopsy.

Case 37.—Primigravida. Age 27. Gestation 7½ months. Prenatal care began in fifth month. B. P. 170/102. Cesarean 2 days after attempted induction with bougie. Elevated temperature. Live baby. Ward free patient. Died 3 days p. p.

Case 126.—Primigravida. Age 31. Gestation 8½ months. Prenatal care began at 2½ months. B. P. 160/100. Alb. 2+. Gain in weight 36 pounds. Cesarean because of toxemia. Live baby. Private patient. Died 18 hours p. p.

Case 130.—Primigravida. Age 19. Gestation 8 months. Six weeks prenatal care. B. P. 118/80, 122/76. Alb. 4+. Induction by bag. Eleven hours' labor. Normal delivery. Live baby, 4 pounds, 4 ounces. Patient developed anuria. Died 4 days p. p.

OTHER TOXEMIAS (6)

This group includes cases of acute yellow atrophy of the liver and toxemia complicated with other conditions: psychosis, hypertension, cerebral hemorrhage.

Two primiparae were not delivered.

Case 27.—Primigravida. Age 36. Gestation 8 months. Cesarean done because of acute yellow atrophy of the liver. Live baby. Ward pay patient. Died 36 hours p. p.

Case 100.—Multigravida. Age 29. Gestation 6 months. No prenatal care. City resident. Six previous labors no dystocia. B. P. 120/80, 150/90. Alb. 2+. Labor 7 hours. Hemorrhage. Question of premature separation of placenta. Stillbirth. Ward free patient. Acute yellow atrophy of the liver. Died 15 days p. p.

Two cases were found in hospital reports but no histories obtained. These were classified as nephritis.

HEMORRHAGE (1)

Case 100.—Described above.

CESAREANS (5)

These patients were all grav i para o and ages ranged from 27 to 36 years.

Case 25.—Primigravida. Eclampsia. Ward pay patient. Stillbirth. Died 24 hours p. p.

Case 27.—Acute yellow atrophy of the liver and chronic nephritis. Ward pay patient. Live baby. Patient died 36 hours p. p.

Case 37.—Albuminuria. Live baby. Ward free patient. Died 3 days p. p.

Case 87.—Eclampsia. Private patient. Stillbirth. Died 1 hour p. p.

Case 126.—Albuminuria. Live baby. Private patient. Died 18 hours p. p.

ANURIA (1)

Case 130.—Brief history under Albuminuria.

SUMMARY

Too many patients had inadequate prenatal care. It is not enough to take a systolic blood pressure, do urinalysis, and tell the patient to return in a month. Often the diastolic blood pressure is more significant. Prenatal care should begin in the first trimester. Patients must be advised regarding diet, (a) to improve general condition, (b) to avoid anemia and (c) to discourage rapid gain in weight. Albuminuria cases as a rule were allowed to continue their pregnancies even after danger signals were present. When toxemia improves under treatment, if the period of gestation is over 7½ months, induction should be seriously considered before the toxemia becomes worse. Too frequently this point is overlooked and the patient suddenly develops eclampsia. In severe cases it is not safe to wait until the foetus is viable.

Rural counties need to improve the prenatal care given to patients. The Community System of Prenatal Care, which provides free care for the indigent and low wage patients in physicians' offices in their neighborhood, has been found to be of practical value in the rural communities. In the urban counties the Maternity System of Prenatal Care has been found more efficient.

In view of the fact that in the large cities there were six patients who had no prenatal care, one had a single prenatal visit, two had less than two months' care although prenatal centers were accessible, it would seem that there is room for improvement in all the counties. Patients must be educated to secure the prenatal care provided for them and to start it early.

144 Harrison Street

A LESSON FROM A DEATH CERTIFICATE

NUMBER THIRTY-FIVE

During the first seven months of 1941 maternal deaths from:

Puerperal sepsis increased 100 per cent;

Toxemia increased 50 per cent;

Ruptured ectopic increased 133 per cent.

Why?

A. W. BINGHAM, M.D.

STATE SOCIETY ACTIVITIES

KIWANIS CLUB SPEAKERS

The Society here acknowledges its gratitude to the doctors listed below, who participated in the talks on "The American Way" given to the 84 Kiwanis Clubs in New Jersey. This list was prepared from copies furnished by the Public Relations Committees of the county societies, and last-minute changes may have escaped notice. The *Journal* would appreciate a memorandum from any member who gave one of the talks and whose name has been omitted from this list.

Many of these doctors gave two talks; and some shouldered the job of delivering three addresses during the week. The list represents a corps of ambassadors sent by our Society to the New Jersey Kiwanis Clubs, an organization of business and professional leaders throughout the state.

Alexander, Samuel F.	Bradley, Robert A.
Allen, Arthur A.	Buchanan, Ralph M. L.
Ballinger, Reeve L.	Burkett, Wendell J.
Barkhorn, Henry C.	Burritt, Norman W.
Blaisdell, C. Byron	Butcher, Charles
Bonanno, Peter J.	Butler, Vincent P.

Cardwell, Edgar P.	Levitas, George M.
Clark, John C.	Lewis, Thomas K.
Cufari, Carmine J.	Livengood, Baxter A.
Dandois, George F.	Morris, Watson B.
Davis, Jacob M.	Norton, James F.
Demarest, J. Willis	Read, Hilton S.
Dodd, William E.	Ristine, Edwin R.
Downs, Roscius I.	Robie, Theodore R.
Farmer, Vincent	Rucker, William C.
Germain, Raymond J.	Schlichter, Charles H.
Griscom, I. Norwood	Sewall, Millard F.
Hawke, Edward K.	Shapiro, Maurice
Hawkes, Stuart Z.	Sheets, Cecil C.
Herrman, William G.	Sherman, William E.
Hubert, Antonio O.	Silvers, Homer I.
Hyde, H. van Zile	Snedecor, Spencer T.
Iraggi, James V.	Stockfish, Robert H.
Jamison, William F.	Townsend, John B.
Jehl, Joseph R.	Underwood, J. Harris
Johnson, V. Earl	Wade, Francis A.
Kerdasha, George S.	Walker, H. Burton
Klein, Edward C., Jr.	Wandall, Frederick G.
Klein, Edward F.	Whims, Clarence B.
Knowles, George M.	White, Frank S.
Lance, Elton W.	Wilkes, LeRoy A.
Lathrop, Frederic W.	Wiley, F. Parker

HOUSE OF DELEGATES

SPECIAL MEETING

At the request of the Board of Trustees, the President has called a special meeting of the House of Delegates for Sunday, November 9, at 2:00 p. m., at the Stacy Trent Hotel, Trenton. At this meeting the Trustees will ask the House of Delegates to consider the recommendation of the Board of Governors of the Medical Service Administration, already approved by the Board of Trustees, that the income limit for Plan 2 be abandoned, and that the payment to participating physicians for medical care rendered under this Plan be placed upon the basis of hospital accommodations se-

lected by the patient. For those patients selecting hospital rooms containing three or more beds per room, the fees paid by the Medical Service Administration will be accepted as payment in full by the attending physician participating in this Plan, while for those patients selecting private rooms with one or the two beds therein, the current payment made by the Medical Service Administration will be regarded only as a credit on account of the total payment of the physician's bill, which will be rendered by the physician as heretofore, on the basis of his own agreement with his patient.

IT'S THE WOMAN'S JOURNAL TOO —

Don't forget that the woman of your household wants to read this *Journal* too. The Woman's Auxiliary section which appears each month is *their* publication. Some Auxiliary

members complain that their husbands hide the Journals so that they do not see them. After you have finished reading this issue, pass it on to the woman of the house.

NATIONAL REHABILITATION PLAN

The National Rehabilitation Program, as explained informally and unofficially to our Medical Preparedness Committee, will cover medical, dental, and hospital services. The cost will be covered by federal funds. The administrative unit will be the Federal Security Agency.

A rehabilitation agency will be established in each state, as will a Rehabilitation Commission to act as a contact organization between Selective Service, welfare organizations and the rehabilitation agency.

At present the Plan provides that all cases will be reviewed by the State Agency and distributed to the medical profession as private cases through a committee of physicians.

Referred cases will be classified as follows:

1. Those capable of paying in full for correction of defects.
2. Those requiring budgeting of expenses.
3. Those requiring partial government subsidy.
4. The indigent, requiring full government subsidy.

The legislative authority will be a new section of the Social Security Act.

It will allow for active administrative participation by the medical profession.

As explained to us the legislation and plan will not be incompatible with Medical Service Administration acting as the rehabilitating agency. Such an arrangement we were told would meet with the approval of the Federal Security Agency and the Selective Service System.

CIVIL SERVICE VACANCIES

Because of the critical need for Medical Officers in the Government, the Civil Service Commission has found it necessary to cancel the Medical Officer examination announced in August of 1940 and to issue another with certain modifications.

The principal changes in the new announcement are: the adding of the option "Public health, general" to the Senior grade and the option "Cancer: (a) Research, (b) Diagnosis and Treatment" to the Medical Officer and

Associate grade; the provision for the acceptance of applications for the Associate grade from persons who have not yet completed internship; the setting back of the date of graduation for the Associate grade to May 1, 1930; and the raising of the age limit for all grades to *fifty-three*.

Further information may be obtained from the Civil Service Commission at the Post-Office Building in Trenton, Camden or Newark.

LONG ISLAND ALUMNI

Alumni of the Long Island College of Medicine are urged to write to Dr. J. J. McGuire at 2 Gould Avenue, Newark, in order that their names may be properly listed in the local list of L. I. C. H. graduates. Dr. Rathgeber,

New Jersey Chairman, will call a meeting in the near future. To assure your placement on the mailing list, please send your name to Dr. McGuire.

STATE ASSESSMENT

ADDENDUM TO TRANSACTIONS

With the approach of the 1942 dues year, we call the following to your attention:

The Finance and Budget Committee at the 1941 Annual Meeting recommended that the state assessment on component county societies

be on the basis of \$16.00 a listed member for the 1942 dues year. This was approved by the House of Delegates at the Annual Meeting in May, 1941.

Annual Red-Cross Roll Call, November 11-November 30. Will you be counted in?

SWINDLER PASSING GOVERNMENT CHECKS

The U. S. Secret Service notifies us that a man alleging to be a soldier or ex-soldier is preying on New Jersey physicians, offering an official-appearing check drawn on "Quartermaster Bank of the United States Army". Thus, he pays an office fee by passing a check for, perhaps, fourteen dollars, collecting the change in cash. This swindler goes by various names — Davis, Levinsohn, Marsden, among others.

He is about 40 years old, 5 feet 9 inches high, weighs 125 pounds; has brown eyes, dark brown hair, sharp features, slender build and may or may not have a small moustache. He probably has pulmonary tuberculosis.

His most recent procedure has been to present himself as a victim of tuberculosis, asking for and receiving pneumothorax treatments.

This he pays for with an over-amount, counterfeited and forged government check.

Physicians who are interested may secure a photograph of this swindler by writing to the U. S. Secret Service, Room 493, Post Office Building, Newark, N. J. If any such person should enter your office, you are urged to detain him on some pretext, and secure police assistance. Incidentally, it is a good idea to demand meticulous identification from anyone trying to pass a government check. Because of their impressive "official" appearance, doctors who would refuse to cash a bank check for a stranger are often misled into honoring these instruments. Safest practice is to deposit the check and have the "patient" return a few days later for his change, thus giving the bank a chance to clear the check and determine its genuineness.

SUPPLEMENTARY LIST OF MEMBERS NUMBER SEVEN

to the

OFFICIAL LIST OF MEMBERS, MARCH 15, 1941

The figures in parentheses refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14), Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

ACTIVE MEMBERS

Bass, Rose D., 54 Lyons av., Newark (7)
Biunno, Anthony J., 83 Wilsey st., Newark (7)
Bolten, Bernard, 291 Osborne ter., Newark (7)
Carr, Alexander M., So. Main st., Metuchen (12)
D'Addario, Anthony R., 118th Field Artillery, 2nd Battalion Aid Station, Fort Jackson, S. C. (7)
DeMichele, Roland V., 103 N. 10th st., Newark (7)
Diener, Samuel, Officers Training Center, 2nd Armored Div. Co. 6, Fort Benning, Ga. (7)
Epstein, Wm., 31 Lincoln Park, Newark (7)
Fishbein, Elliott, 70 Carroll st., Paterson (16)
Fisher, Stella C., 4401 Westfield av., Camden (4)
Gelb, Jerome, 84 W. Alpine st., Newark (7)
Goodman, Kenneth, 141 Park av., East Orange (7)
Greenfield, Herbert, 565 Bergen av., Newark (7)
Greifinger, William, 22 Vassar av., Newark (7)
Guernsey, F. West, Phillipsburg (21)
Jacobs, Wm., Station Hosp., Fort Bragg, N. C. (7)
Knowles, Frederick E., 103 Church st., Boonton (14)
Lehman, David J., Jr., 1 Highwood rd., W. Orange (7)
Levine, David B., 647 Broadway, Paterson (16)
Marrocco, Wm., 88 Vreeland av., Paterson (16)
Meinhard, Fred, 154 Van Buren st., Newark (7)
Messina, Thos., 153 Freeman av., East Orange (7)
Meyers, Francis R., 627 E. 24th st., Paterson (16)
Michelson, Henry, 258 Park av., Paterson (16)
Monaloy, Morris A., 24 Day st., Clifton (16)

Neare, Clifford, 2 Hawthorne av., East Orange (7)
Ondovchak, M. Frederic, Kings Hwy., Mt. Ephraim (4)
Paris, Wm., 1st Eng. Bat., Ft. Devens, Mass. (16)
Pasternack, Elroy, 255 Harrison st., Passaic (16)
Pink, Solomon H., 21 High st., Butler (16)
Pollock, Franklyn J., 14 Watson av., Newark (7)
Rauschenbach, Paul E., Jr., 174 Carroll st., Paterson (16)
Riffin, Irving M., 419 Park st., Upper Montclair (7)
Schachter, H. A. H., 6 Milford av., Newark (7)
Schoenau, Carl W., 1 Park pl., Bloomfield (7)
Shangold, Jack E., Sergeantville (10)
Shipman, Meyer P., 237 Broadway, Paterson (16)
Stone, Russell B., Phillipsburg (21)
Tell, M. Edward, 249 Lexington av., Passaic (16)
Williams, Wm. C., B'kH.Pk. & Wayne av., H'd'nHt. (4)
Yachnin, Samuel C., 32 Ridge rd., Lyndhurst (16)

ASSOCIATE MEMBERS

Burstein, Leo Q., 702 S. 15th st., Newark (7)
Gobel, Stanley J., 79 Talmadge av., M'dl'sxBoro (12)
Keim, Wm. F., Jr., 25 Roseville av., Newark (7)
Lima, John G., 292 Broadway, Paterson (16)
Long, John F., 205 N. 4th st., Harrison (7)
Lucy, James J., 184 Market st., Perth Amboy (12)
Salaky, Wm. L., 387 Neville st., Perth Amboy (12)
Vargyas, Joseph C., 116 New st., New Brunswick (12)
Weinstein, Leopold, 82 Lyons av., Newark (7)

Annual Red-Cross Roll Call, November 11-November 30. Will you be counted in?

ACADEMY OF MEDICINE OF NORTHERN NEW JERSEY

The Academy of Medicine inaugurated its thirty-first year at a special "house-warming" meeting on October 16. Feature of the session was the formal opening of the Eagleton Medical Civic House, a brownstone mansion adjoining the Academy's building at 91 Lincoln Park, Newark. The new Medical Civic House, a gift of Dr. and Mrs. Wells P. Eagleton, is joined by archways on each floor to the corresponding rooms of the Academy building.

Dr. Edward W. Sprague, President of the Academy, announced that Mrs. John Condon had given the Academy the extensive medical library accumulated by Dr. Condon during his active medical career. Announcement was also made of the gift to the Academy museum of the Past-President's keys of the late Dr. Francis Haussling.

Dr. Sprague praised the work of Dr. Joseph A. Clarken, Chairman of the Committee on Alterations, for his successful formulation and execution of the alteration plans. Mention was also made of the faithful housekeeping services of Mr. and Mrs. Ruh, the Academy custodians; of the efficient work of Miss Mildred Naylor, the Librarian; and of the appointment of Dr. Walter B. Mount of Montclair as Curator of the enlarged Academy of Medicine Museum.

Dr. Sprague stressed the importance of health in the National Defense program, and indicated the ways in which the Academy of Medicine served to keep physicians in the forefront of the battle against disease. Gratitude was expressed to Dr. and Mrs. Eagleton for their magnificent gift. The arrangement and functions of the many rooms in the Eagleton Medical Civic House were outlined. Dr. Sprague lauded Dr. Clarken's success in consummating the plans, "against priorities, personalities and the perversity of inanimate objects". Mrs. Eagleton, described as the "prime mover in the donation of the gift", was introduced to the audience and affectionately applauded.

Dr. Sprague enumerated the 17 Presidents of the Academy who had preceded him. In tribute to the five deceased Presidents (Drs. Dickinson, Strasser, Hagerty, Haussling and Charles Ill), the audience arose for a moment of silence. Of the surviving ex-Presidents, all but two were present at the meeting, and they were introduced to the audience by Dr. Sprague. The ex-Presidents present were Drs. E. J. Ill, H. S. Martland, H. B. Epstein, H. J. Wallhauser, E. Z. Hawkes, E. E. Reissman, W. P. Eagleton, A. W. Bingham, Max Danzis, H. C. Barkhorn and C. M. Robbins.

Dr. Sprague then briefly mentioned the many contributions of Dr. Eagleton as a physician and a citizen, and introduced him to the cheering audience.

Dr. Eagleton urged that the physician play a more dynamic rôle in civic leadership, and indicated that Mrs. Eagleton and himself had felt that by providing a place where doctors might freely discuss social and political problems having medical aspects, a distinct contribution would be made to the civic development of the physician. He reminded the audience that before the 19th century, physicians had always been community leaders, and deplored the fact that today leadership has been so often allowed to slip into "uneducated and selfish hands". The life of the Republic, Dr. Eagleton said, depended on the activity, leadership and participation of intelligent and responsible citizens; and physicians, while certainly intelligent and responsible, were too often civically inactive. The profession's shirking of communal responsibility on the grounds that "it did not want to mix in politics" was characterized as a threat to the profession, and indeed, to the entire democratic way of life.

The Eagleton Medical Civic House was accepted for the Academy by *Dr. Edward J. Ill*, first President of the Academy and Senior Fellow of The Medical Society of New Jersey. Dr. Ill described the new building as a means of adding to the vitality of the Academy, increasing its usefulness, advancing our calling and raising our sensitivity to our civic duties. The audience was reminded that the medical profession in general and the Academy in particular had always been indebted to Dr. Eagleton because of his tremendous activity in medicine, and that this gift doubled our debt to him. Dr. Ill expressed ringing pride in the Academy itself, in the chance it provided for bringing to New Jersey distinguished physicians from all over the country, in the facilities it afforded for study and research.

The President introduced the chief speaker of the evening, *Dr. Howard W. Haggard*, Director of the Laboratory of Applied Physiology of Yale University, who spoke on medical change and social change. Dr. Haggard stressed the way in which medical thought and medical progress were geared to the culture of the day. Medicine, he felt, was an integral part of an integrated society, and not an autonomous science sealed in a social vacuum. The "usual state of medicine is that of stagnation, sterility and complacency, punctuated by short periods of progress". Medical genius, said Dr.

Haggard, is not so much an individual accomplishment, as a result of the culture of the times.

Dr. Haggard's address was followed by a collation and by a conducted tour of the new building, with members of the Woman's Auxiliary to the Essex County Medical Society acting as hostesses and guides.

ACADEMY NOVEMBER PROGRAM

The Academy of Medicine of Northern New Jersey announces the following program for November. All meetings are held at 8:45 p. m. in the Academy's Building, 91 Lincoln Park, Newark.

Thursday, November 6

4:30 p. m.—Council Meeting

Monday, November 10

8:45 p. m.—Eye, Ear, Nose and Throat Section of the Academy

"The Problem of Reading Disabilities", Grace M. Kahrs, M.D., Newark; Brittain F. Payne, M.D., New York.

Tuesday, November 18

8:45 p. m.—Stated Meeting under the auspices of the Section on Medicine and Pediatrics

"The Present Status of Chemo-Therapy", Wallace E. Herrell, M.S., M.D., Consultant to Section on Medicine, Mayo Clinic.

Tuesday, November 25

8:45 p. m.—Section on Surgery

"Experiences with Compound Fractures in Modern Warfare", illus. slides and movies—Frederick W. Waknitz, M.D., Orthopedic Surgeon with the American Hospital in Britain.

"Skin Grafting of War Wounds", illus. slides and movies—John Marquis Converse, M.D., Plastic Surgeon with American Hospital in Britain.

Friday, November 28

8:45 p. m.—One-hour program of colored movies

"Vaginal Hysterectomy, Suture Method, for Uterine Prolapse", Dr. Louise E. Phaneuf, Boston

"Abdominal Complete Hysterectomy for Fibroids", Arthur H. Curtis, M.D., Northwestern University Medical School, Chicago

Sponsored by the Committee on Public Health and Medical Education.

TEAMWORK IN PEDIATRICS

So appealing is the challenge of child health and welfare that many organizations—governmental, professional, and lay—are working simultaneously in this one field. Fortunately, the often unavoidable overlap, organizational rivalries, and duplication of work are not seriously hampering our child welfare programs. This is due to two factors: leadership and co-operation.

On a nationwide front, the American Academy of Pediatrics is the natural leader in the child health field. In terms of actual individual work with children and parents, however, the doctor himself should direct this program. We are fortunate in New Jersey in having both the Regional Chairman and our Society's Executive Officer serving as State Chairman for the American Academy of Pediatrics. This

service—heartily endorsed by our Society's Board of Trustees—permits these members to act as liaison between The Medical Society of New Jersey and New Jersey members of the Academy, and thus assures the integration in New Jersey projects undertaken by the Academy for the Medical Society. The success of this coöperative plan is symbolized by the large amount of space devoted to New Jersey material in the Journal of Pediatrics, and by New Jersey's position in the forefront of child health and welfare work. New Jersey pediatricians thus effectively integrate their two rôles: membership in the Medical Society and membership in the Academy of Pediatrics—without conflict or lost motion. In other specialized fields it may be possible to imitate such integration and effort.

CORRECTION

In printing of "Neurogenic Factor in Peripheral Vascular Diseases" by J. F. Pessel, M.D., in the September Journal, quotation marks were misplaced so that some of the material quoted verbatim from papers by Ochsner and DeBackey was inadvertently ascribed

to other authors or was so set up that it appeared to be the author's words when, in fact, it was direct quotation. Both Dr. Pessel and the Publication Committee regret this error, and in fairness to Dr. Ochsner and Dr. DeBackey, we make this correction.

MEDICAL OPPORTUNITIES IN CIVIL SERVICE

By V. K. HARVEY, M.D., Medical Director, and E. P. LUONGO, M.D., Medical Officer, U. S. Civil Service

Until recently, the opportunities for a career as a Federal medical officer, other than those afforded in the Army, Navy and Public Health Service, have not received due consideration by the medical profession in the United States.

OPPORTUNITIES

Because of the present national emergency, large numbers of recent graduates of medical schools have been employed by the armed forces of the nation. This has brought about an acute shortage of physicians available for employment in the civil service. The medical functions of the other Government agencies, however, must go on both in peacetime and during a national emergency.

The ranks of medical officers already in the various Government agencies will be depleted by retirement of the older doctors and by entrance of the younger doctors into active military duty. Hence, effort is being made to build up the staffs of these agencies with young physicians who wish to make the Federal service a career. A physician in the civil service may participate in any phase of medical activity, ranging from a rural practice to the most highly specialized fields.

TYPES OF SERVICE

Not all civil service physicians are employed in large Government hospitals. On the contrary, a considerable number are engaged in the general practice of medicine. Thus, the Indian Service has a very active outpatient department connected with its hospitals, and many of its physicians make home calls, make field trips, conduct school examinations, and administer general public health measures among the Indians.

It is in the fields of general practice, tuberculosis, psychiatry, surgery and public health that the largest number of Federal medical officers are engaged. The opportunities for research in these and other fields of medicine are excellent. Because of the emphasis placed on career service by modern personnel administration, "in-service training" is playing an important part in the life of the young Government physician. In the Veterans Administration, "in-service training" affords opportunities for graduate study. The Veterans Administration operates a large tumor clinic at Hines, Ill., psychiatric clinics at its various hospitals, chest

surgery clinics at the tuberculosis hospitals, and at Mt. Alto Hospital, Washington, D. C., it conducts a heart research clinic. These clinics afford excellent teaching opportunities for young physicians.

At St. Elizabeth's Hospital, Washington, D. C., fine opportunities for residencies and internships in neuropsychiatry are open; these residencies and internships rank among the best in the United States. St. Elizabeth's Hospital is under the jurisdiction of the Federal Security Agency.

CANAL ZONE

Physicians may be employed under civil service as far south as Panama and as far north as Alaska. In the Canal Zone, the physician interested in tropical diseases may receive excellent opportunities to study that subject. Civilian physicians in the Canal Zone are appointed mainly for dispensaries and for quarantine work. The dispensary work consists of general practice involving the attending of Government employees and their families, crews and passengers of vessels, etc. The work of quarantine physicians consists of inspection of crews and passengers on incoming vessels.

ALASKA

Positions in Alaska under the Indian Service will appeal to physicians who have an adventurous spirit, as will positions in the Coast and Geodetic Survey, which afford an opportunity for young physicians to spend some time at sea on Coast and Geodetic Survey vessels. The task of physicians employed in Alaska under the Indian Service is a formidable one because of the climate and the remoteness of some of the villages. However, young physicians of robust health who go to that area have an opportunity to render a great service to humanity.

FOOD AND DRUG ADMINISTRATION

The functions of medical officers in the Food and Drug Administration of the Federal Security Agency have become of increasing importance since the passage of the Federal Food and Drug Act. Medical officers in the Food and Drug Administration are engaged in a critical review of the labelings of medicines in the light of their composition for the purpose of ascertaining whether the therapeutic repre-

sentations are true. This work offers excellent opportunities to graduates who have had experience in pharmacology.

CHILDREN'S BUREAU

Also of increasing importance have been the medical functions of the Children's Bureau in the Department of Labor. The Child Hygiene Division of the Bureau carries on research and investigation involving fundamental technical medical study of the mental and physical condition of children in relation to heredity, environment, nutrition, and the efficacy of various methods of community health work. There are opportunities in this Bureau for young physicians with special training in pediatrics, obstetrics, or public health procedure, who are interested in extensive research and study in connection with maternal and child health and services to crippled children.

PUBLIC HEALTH SERVICE

In the Public Health Service, there are, in addition to the commissioned force, medical officers who are appointed under provisions of the Civil Service Act and rules. These medical officers are appointed as Acting Assistant Surgeons and are usually detailed for local duty in the vicinity in which they reside. From time to time, however, there is opportunity for them to transfer elsewhere. Acting Assistant Surgeons are employed in connection with practically all the activities of the Public Health Service. These include hospital and relief work, quarantine and immigration work, field investigations, and epidemic control duty. The Public Health Service operates marine hospitals and relief stations throughout the United States. The beneficiaries in these hospitals and relief stations consist principally of merchant seamen, officers and enlisted men of the United States Coast Guard and civil employees of the Federal Government injured in line of duty.

The services of Acting Assistant Surgeons are utilized at a large number of marine quarantine stations in connection with the inspection of vessels entering the United States from foreign ports, and in connection with the medical examination of aliens entering this country. There are opportunities in the Public Health Service for Acting Assistant Surgeons to conduct investigations pertaining to industrial hygiene, goiter, anthrax, influenza, malaria, pellagra, pneumonia, tuberculosis, typhoid fever, child hygiene and public health administration.

Medical officers in the Government Printing Office are in charge of a small well-equipped hospital in which employees who are injured or become ill while on duty are treated. The

Bureau of Engraving and Printing requires the services of a physician for similar duty. The Census Bureau employs physicians in medical statistical study. In the Civil Service Commission a number of medical officers are engaged in medical activities pertaining to Government employment and disability retirement. This activity is a combination of insurance, industrial and administrative medicine and affords physicians a basic training unique in the United States.

VETERANS' ADMINISTRATION

The medical service of the Veterans Administration is comprised of regional offices, facilities and diagnostic centers. The term "facility" is applied to various types of field stations, including those which are hospitals only, those which may provide domiciliary care and hospitalization, others which are a combination of regional offices and hospitals, and still others which are a combination of regional offices and homes.

The diagnostic centers were established for intensive study and observation of patients presenting diagnostic problems, and have consultant staffs consisting of physicians with national reputations in their fields.

Clinics for diagnosis and treatment of malignant growths are located strategically in facilities in New York City, Washington, Atlanta, Portland and Los Angeles.

In nine facilities, scattered throughout the country, centers have been created for special chest surgery.

At the Veterans Administration, research is supervised by specially trained physicians on the staff of the Medical Director, and projects are entrusted to physicians having the basic specific qualifications to conduct them.

SALARIES

The chances for early appointment of recent graduates of Class A medical schools who have served an approved internship are good. Open continuous examinations have been announced by the Civil Service Commission to fill vacancies in the position of Associate Medical Officer. Physicians appointed to these positions in the Veterans Administration have excellent chances for promotion. If their records are satisfactory, they may look forward with reasonable certainty to a step-up in grade and salary within the first two or three years of their service. The cardinal criterion for advancement in the Veterans Administration's medical service is demonstrated ability.

The majority of physicians are appointed in the Associate grade and receive a compensa-

tion of \$3,200 a year minus a $3\frac{1}{2}$ per cent deduction for retirement purposes. The opportunities offered for advancement to \$4,600 and \$5,600 a year are good, and many physicians who demonstrate that they have administrative ability in addition to a sound medical background may advance to \$6,500 and \$7,500 a year. A physician should not expect to accumulate a fortune when choosing a medical career in the Government service; however, he can look forward to a lifetime of adequate remuneration for his service, satisfactory employment hours, and adequate annual and sick leave with pay. He will in addition receive

disability and age retirement insurance at a very low rate.

CONCLUSION

The most important consideration is the opportunity for which every physician is searching, that is, an opportunity to practice his profession and render efficient service to unfortunate human beings. The United States Government offers this career in medicine, surgery, public health, and other specialties which should be of interest to all recently qualified physicians.

—Abstracted from Medical Annals of the District of Columbia, September, 1941.

CIVILIAN MEDICAL DEFENSE

According to a joint statement issued on September 4 by the U. S. Director of the Office of Civilian Defense, F. H. LaGuardia, and the Chairman of the American National Red Cross, Norman H. Davis, State and local defense councils are the official agencies responsible for the coordination of all available resources which may be required for civilian protection in the event of belligerent action. Defense Councils should therefore acquaint themselves with the resources of the local Red Cross Chapters in providing food, clothing, shelter, nursing care, transportation, and other basic necessities and should integrate them into the comprehensive local program. Duplication of trained and experienced personnel and of available supplies of the Red Cross should be avoided except where supplementation is essential to meet the anticipated needs of the community.

The U. S. Director of Civilian Defense recommends that all approved general hospitals proceed without delay with the organization of a field casualty service. Hospitals which have already established Emergency Medical Field Units for this purpose should revise their organization so as to conform with these plans. Uniformity in organization is essential if Medical Field Units are to respond promptly and effectively to emergency calls from the local Control Center. The provision of special medical and surgical equipment for Field Units should await distribution of Bulletin No. 2 of the Medical Division, which will deal with equipment.

Most medical facilities from which the civilian defense organization in each state is to be developed are at the local level. It is therefore advisable that a local Chief of Emergency

Medical Services be appointed. To facilitate coordination of these facilities, official representation of the medical, public health and nursing professions on the local Medical Advisory Council is necessary. It should be the responsibility of the State Council of Civilian Defense to define defense areas around metropolitan centers and to weld these areas into co-operating units.

In the event of enemy attack, the operation of the local Emergency Medical Service may be sketched as follows: Air raid warnings will come to the local Control Center from the military establishments in the area and will be relayed to the proper Civilian Defense Officers; information concerning the location and extent of local damage will be received by the Control Center from Air Raid Wardens or others. Using a spot map showing the location of hospitals, medical supply depots, transportation centers and sites for the establishment of Casualty Stations and First Aid Posts, the Control Center or its substation will call out an appropriate number of Emergency Medical Field Units. To be prepared to respond promptly and effectively, emphasis should be laid upon the necessity for field drills of Medical Units in collaboration with Rescue Squads, Stretcher Teams and other emergency relief services.

In the preparation and execution of these plans, State and local Defense Councils may avail themselves of the assistance of the liaison officers of the U. S. Public Health Service attached to headquarters of the Army Corps Area.

GEORGE BAEHR, M.D.,
Chief Medical Officer,
Office of Civilian Defense.

THE IMPROVEMENT OF SCHOOL MEDICAL SERVICE

III.

Prepared by the Committee on School Health of the American Academy of Pediatrics

The Committee recommends that the routine examination be limited in frequency according to the budget so as to allow time for sound education of parents, children, and the school staff. The frequency of the routine examination should also allow for time for accurate detection of the cases likely to need medical care and for careful judgment of the physician in giving advice; and to provide time for guidance in the use of the community medical facilities to assure adequate care.

The physician should not be required to make so many routine examinations that he does not have time to get enough history to permit him to understand the needs of the child selected for recommendations. School medical problems are not limited to well-defined diseases requiring medical care, nor to physical handicaps which can be corrected by operation or glasses. Insufficient rest, inadequate diet, or bad management leads to nervousness or excessive irritability. There may be other adjustments necessary for attaining normal growth and development or such a healthy functioning as will permit him to attain resistance to fatigue and bodily vigor. Many minor adjustments to his home care or management, and early treatment of minor ailments, may mean much in achieving his inherent potentialities. So the physician should consider the *whole* child; and in order to guide the parent to make use of the medical facilities that may be available, the physician should interpret the degree of severity of the physical signs, symptoms, and adjustments necessary for the parent to understand the importance of obtaining treatment or further advice. Such a school service must necessarily limit the frequency of routine examinations.

DISTRIBUTION OF MEDICAL SERVICE

Another problem is the accumulation of evidence of unmet medical needs. The schools, with a complete coverage of all the children, with records and with a follow-up service, should be able to provide all the evidence needed to determine the adequacy of medical facilities for all groups of school children. School records should show all cases of medical neglect. The school physician and nurse, with the other school staff, are often familiar with those who do not secure proper medical service because of limited income or because of the circumstances in which they live. Such information

is essential for any scheme for a proper distribution of medical service; yet accurate information is practically never organized nor presented to meet the needs when the school physician and nurse are overloaded with routine examinations and inspections.

STATE LAWS

State laws in many states, as well as educators without understanding of medical standards, often demand routine examinations in the schools without consideration of the budget available for physicians, or for nurses to assist in follow-up. These demands for examinations, more frequent than can be carried out effectively, are made without understanding their effect on the whole school health program. The physicians and nurses who must face these demands are often not responsible for planning the integration of the whole school health program. They are unprepared to plan any means of relief from the overload which nullifies the whole purpose of the examinations. Therefore, the decision as to the frequency of these examinations must be made according to a plan that coordinates the many aspects of the school health program, as well as the community health service.

PLAN NEEDED

For wise decisions and sound coordination we recommend an organization plan with a *medical supervisor* or *general school medical adviser* from the Department of Health, or School Department. Such a medical adviser should be trained in public health, with an understanding of educational administration. He should act as adviser and coordinator for a county or such a unit of organization as is consistent with Health Department or Education Department administration. Such a medical administrator or adviser should have the advice of both the executive staff of the schools, the leaders of organized medicine, and the Health Department.

Either part or full-time physicians serving schools in a program with such an organization could have the program planning necessary for maintaining medical standards and efficient coordination of all activities according to the limits of a given budget. Clerical tasks and routine procedures that do not require medical judgment and skill, such as audiometer tests, Snellen tests, and anthropometry, are parts of the service requiring planning for

economy of effort to meet the requirements of a well-rounded program. The teacher's observations of her pupils make a significant contribution to the discovery of children in need of medical care when the program is planned. The physician and nurse must have a plan which fits in with the health education of the classroom, the gymnasium, and the playground. Planning is required to persuade parents to come to school for individual conferences. Letters to parents, and education through the Parent-Teacher Association, are all part of the planning. The health examination reports of the private physicians, as well as their recommendations on referred cases, should also be included as important contributions. Then the routine examinations fit into a pattern of service. They can be carried out according to limited, explicitly defined routine, so as to allow time for sufficient further appraisal of the *whole child* whenever recommendations should be made to the parent or the school staff. With such planning of the program there can be explanations to the nurse so that her follow-up advice to the parents can carry through to a proper use of the available medical facilities.

A MEDICAL ADMINISTRATOR

With recognition that a full and complete health supervision service, such as is proposed as an ideal, is impossible with a limited budget, we must realize that the frequency of examinations must be adjusted according to a variety of factors. When the planning of this adjustment is left to an individual staff physician in an individual school unit, the physician is seriously handicapped. Instead of being able to plan for the place of a physician in the whole school health program, the physician is usually required to bid for a job. Salary and the amount of work he will do become confused with his desire to avoid attempting too much. Intelligent planning to obtain the maximum amount of service for the children, with a limited budget can best be carried out by a *medical administrator or adviser* with the support and advice of representatives of the medical profession. With such units of organization, the medical profession may exert a proper influence upon the character of medical service. The extent or adequacy of the screening routine or technique can be determined according to the

time allowed for the physician in proportion to the number of pupils, and the number who go to a private physician for examination; and according to the facilities for follow-up, and the facilities for correction or treatment. Then there is no accumulation of records of defect cases that cannot be followed up, but the more serious cases are given first attention, and the pupils requiring free or part-pay facilities for correction are selected according to the urgency of their needs.

RECOMMENDATIONS

1. The medical profession should bear the responsibility for the character of the service; and an organization plan should be provided to make this possible.

2. The American Academy of Pediatrics has formulated a measure of the least amount of medical health supervision that an average child must have to assure him of the best possible physical and mental health by the time he has reached the end of the growing period.

3. The Academy warns against misrepresentation of the school service by promising more than can be delivered, and recommends that plans be developed for progress toward the ideal, rather than attempt too much.

4. Progress toward the best possible health supervision for all children should be founded upon education; and the physician in the schools should have time to develop the program of education for attitudes of desire and purpose that will create a demand for the best modern medical service.

5. The school medical service should discover the children most likely to be in need of medical care, and provide such follow-up and guidance in the use of the community medical facilities as is necessary to meet the needs of the children.

6. To maintain proper standards of medical service, and to provide medical advice that meets the needs of the children, there must be certain limitations of the service according to the limitations of the budget.

7. Planning the work of the physician in the schools to obtain the maximum contribution for a given budget can be carried out most effectively through a medical administrator or adviser, with the support and advice of representatives of Organized Medicine.

Note The Journal invites readers to submit their comments on this report and on the proposed recommendations.

COUNTY SOCIETY REPORTS

ATLANTIC COUNTY

Sloan G. Stewart, M.D., Reporter

New Jersey doctors were given the highest praise for the handling of Selective Service examinations and their rehabilitation plan for the corrective treatment of those rejected in an address by Col. Charles H. Schlichter, M.D., Chairman of the Medical Preparedness Committee of The Medical Society of New Jersey. Dr. Schlichter was the guest speaker at the October 10 meeting of the *Atlantic County Medical Society* held at the Hotel Traymore in Atlantic City. The timely subject for discussion was "The Status of the Doctors in New Jersey as Observed by the State Medical Preparedness Committee of the A.M.A." He urged physicians to take active part in local defense councils, and to cooperate with the Red Cross in First Aid classes and in helping to train nursing aids for emergency medical field units. It was emphasized that there would be both a military and civilian defense phase in the program and that both of these were to be under medical direction.

The speaker pointed out that of approximately 88,000 selectees examined in this state under Selective Service, 28,000, or about 29 per cent, had been rejected. This is a much lower rate than one frequently hears quoted. Major causes of rejection were dental, visual, auditory, cardio-vascular and psychoneurosis.

This paper was discussed by Dr. Robert A. Kilduffe, Chairman of the Atlantic County Medical Preparedness Committee, and by Dr. William J. Carrington, Chairman of the Medical Practice Committee.

Dr. Harry Subin, President of the County Medical Society, presided at a brief business meeting. Dr. Carl Surran urged the physicians to attend the meetings of the American Public Health Association held in Atlantic City October 12 to 17.

BURLINGTON COUNTY

T. B. Dickson, M.D., Reporter

The October meeting of the *Burlington County Medical Society* was held on the ninth at the Moorestown Field Club.

The President, Dr. LeFavor, welcomed the following guests: Drs. Betancourt and Mecray of Camden County; Drs. Diverty, Wood and Nelson of Gloucester County; and Dr. Ralph K. Hollinshed, First Vice-President of The Medical Society of New Jersey.

Dr. Freeman Metzger introduced the principal speaker, Dr. Richard Meade Jr., Assistant Surgeon to the Episcopal Hospital of Philadelphia. His topic was "Recent Advances of Thoracic Surgery of Interest to the General Practitioner". He stressed the importance of early diagnosis and urged the more frequent use of x-ray. He reviewed modern surgical treatment of constrictive adhesive pericarditis, coronary occlusion, angina pectoris, tuberculosis and chest tumors.

The resignation of Dr. John R. Siddall was ac-

cepted with regret. Reason for his resignation is his moving north to take a residency in obstetrics and gynecology at the Margaret Hague Maternity Center in Jersey City, and at the Sloane Hospital in New York.

Dr. Abraham Sands of Burlington was elected to the membership in the County Society. Dr. Sands, after practicing in Burlington for several years, was taken into the Army Medical Corps on October 10, 1941, and is stationed at Fort Dix.

Dr. Ralph K. Hollinshed, First Vice-President of The Medical Society of New Jersey, made a short speech in which he asked for complete cooperation in the Medical Preparedness activities and the Medical Service Administration.

The next session of the County Society will be the Annual Meeting, at which officers for the coming year are to be elected and at which committee chairmen are expected to report on the past twelve months.

CUMBERLAND COUNTY

E. C. Lyon, M.D., Reporter

Dr. E. J. Marsh, President-Elect of The Medical Society of New Jersey, and Dr. Roscoe W. Teahan, Chief of Staff at Jeanes Hospital, Fox Chase, Pa., made addresses at the meeting of the *Cumberland County Medical Society* held Tuesday, October 11, at the Cumberland Hotel. Two new members were welcomed, Dr. A. L. Grizzo of Vineland and Dr. Thomas Sheppard of Millville.

Dr. W. Sherman Garrison of Cedarville, the President, presided and several communications were read and discussed. An amendment to the by-laws, automatically making the retiring President a member of the Executive Committee for one year, was adopted. The Executive Committee also recommended consideration of a plan to bring about uniformity of fees charged throughout the county for office visits. This was put in the form of a motion and passed, but it is understood that it will have the force of a recommendation only.

In his address, Dr. Marsh stressed the desire for more local articles of scientific research to be submitted to *The Journal*. Dr. LeRoy Wilkes of Trenton explained the new features of Medical Service Administration of New Jersey.

Dr. Teahan spoke on "Clinical Aspects of Superficial Cancer". This was highly informative and slides were shown to illustrate the early stages of cancer. Many questions were asked the speaker about his study of and treatment for malignant growths.

ESSEX COUNTY

Paul H. Hosp, M.D., Reporter

The *Essex County Medical Society* held its regular monthly meeting on Thursday, October 9, 1941, at the Academy of Medicine in Newark. Dr. Francis C. Weber, President, called the meeting to order at nine o'clock. Minutes of the last meeting and those of the Council meeting were read. The guest speaker was then introduced.

In his introductory remarks, Dr. Weber let us know that Dr. Harold W. Jones, Associate Professor of Medicine, Jefferson Medical College of Philadelphia, was a classmate of his and that he was a native Newarker. He had made Newark his home until 1911.

Dr. Jones began by giving the history of transfusion. He linked such notables as Crile, Lewison and Unger with its forward strides. He spoke on the value of blood and plasma in transfusion. Citrated blood, he said, is safer for general use. Everybody can not use whole unmodified blood. He stated: "The Blood Bank was due to the failure of the Whole Blood method; that is our not being able to get donors when needed."

In regard to plasma, he said that this can be stored a long time, especially when prepared by the "Hill" Method. This is an isotonic plasma. Doctors can combat shock with plasma and later use stored or whole blood. Plasma saves lives.

A motion picture was then shown of the methods used in collection and storing of blood and in the preparation of plasma.

A discussion followed in which Drs. Levine, Katzin and Yaguda took part.

The meeting was most interesting and about 200 members attended.

The Essex County Medical Society approved the proposal of the Medical Service Administration to abandon the income ceiling for subscribers to the plan included in Plan Number 2 (the Hospitalization Plan). At the end of one year this will be subject to revision. Our practical experience with its operation may indicate such action.

The following physicians were unanimously elected to membership:

To Active Membership: Drs. K. F. Friedlander, A. P. Grasso and N. M. Smith, all of Newark; Dr. L. J. Olini of East Orange, Dr. B. E. Ward of Arlington.

To Associate Membership: Drs. L. Q. Burstein, W. F. Keim, Jr., C. J. Modzelewski and Leopold Weinstein, all of Newark; Drs. K. M. Bremer and J. M. Rowe of East Orange; Dr. F. J. Dann of Irvington; Dr. D. J. Lehman of West Orange; Dr. John F. Long of Harrison; and Drs. T. W. Murphy, Jr., and Robert E. Lee of Short Hills.

Reinstated: Dr. Leo Kohn of South Orange and Drs. Giovanni Fasano and Michael J. Coffey of Newark.

Announcement was made of the talks and motion-picture exhibitions to be given to the laity jointly by the Contemporary of Newark and the Essex County Medical Society. Attention was called to the list of graduate courses available. (See page 538 of the October *Journal*.)

GLOUCESTER COUNTY

C. A. Bowersox, M.D., Reporter

Good, old-fashioned hard work will be the cure for America's post-emergency troubles, members of the *Gloucester County Medical Society* were told at the Annual Meeting on October 17.

Declaring that if this policy is followed, there need be no worry about the future, Allen A. Stock-

dale, D.D., of New York City, recalled that America has "always been a challenge".

Dr. Stockdale, a former clergyman now associated with the American Association of Manufacturers, pointed out a number of our everyday items of life which in his boyhood were undreamed of. By this inference, he said that the items to be produced by industry in the future would sound crazy today.

Included in his forecast for the years to come were family airplanes, low-cost air conditioning for autos and homes, air-conditioning for entire cities, telephone television, cast iron which will bend, a device which will dispel fog, cheaper electricity, waterproof paper, rubber which won't skid on wet highways, wood which can be welded, stainless copper and brass, noise eliminators and a score of other items.

Dr. Stockdale warned his listeners that "this is no time to be defeated, or scared or all-done-in". In a voice which rang with optimism, he pointed out that American industry in one year had done what it took Adolf Hitler six years to do, and added that under these conditions "Hitler hasn't the ghost of a chance to ultimately become the ruler of the world".

The speaker advised that we have to "get the inspiration of the pioneers", and added that "God left the world unfinished that we might have the joy of finishing it".

"Our future is linked to vision and to work, but it's a glorious future," Dr. Stockdale concluded.

Dr. Stockdale's address was preceded by remarks by Thomas K. Lewis, M.D., President of The Medical Society of New Jersey, who said the medical profession has always had socialized medicine, that it has it today, and that it will have it more so in the future. He pointed to the need for "ability to control our forces in the new direction".

Dr. Frederick G. Wandall, of Clayton, President of the Gloucester County Society, was toastmaster, and the guests were introduced by Dr. Chester I. Ulmer, of Gibbstown, the county Secretary.

Music was provided by the Clarence Fuhrman trio, with vocal numbers by Evelyn Russell Hanscom, soprano.

The committee on arrangements was headed by Dr. Clarence A. Bowersox, Dr. Joseph F. Hughes and Dr. Baxter A. Livengood, all of Woodbury.

Guests present were: Dr. and Mrs. LeRoy A. Wilkes, Trenton; Mrs. Edith L. Madden, Dr. and Mrs. Herbert T. Kelly, Philadelphia; Dr. and Mrs. William T. Lemon, Senator and Mrs. Robert C. Hendrickson, Dr. and Mrs. Oram R. Kline, Woodbury; Dr. William F. Costello, Dover, N. J.; Dr. and Mrs. Franklin H. Church, Salem; Dr. and Mrs. Hammell P. Shippis, Delanco; Dr. and Mrs. Harry F. Suter, Pennsgrove; Assemblyman and Mrs. John G. Sholl, Pitman; Dr. George B. German, Camden; Dr. and Mrs. Frank L. Perry, Woodstown; Mrs. Charles Pedrick, Mrs. Carrie Rogers, Mr. Malcolm Douglass, Mr. Robert M. Ulmer, Mr. Clark Fleehart, New Mexico; Mr. Bud Muench, Syracuse, N. Y.; Mrs. Marshall Lummis, Mr. and Mrs. George P. Robins, Mr. Welling G. Schrack, Miss Bertha Bush and Mrs. Douglass.

HUDSON COUNTY

J. N. Connell, M.D., Reporter

Regular meeting of the *Hudson County Medical Society* was held on October 7, 1941, at the Masonic Club, Jersey City, N. J. The session was called to order by the President, Dr. Anthony J. Conty, at 9:15 p.m.

Dr. R. Stockfish, President of the Masonic Club, welcomed the Society to the Masonic Club. He urged the members to feel that they are at their own club, and told them that they are welcome to drink, eat and make merry in any part of the building.

Minutes of the regular meeting and Executive Committee meeting were approved as printed in the Bulletin.

Dr. S. A. Cosgrove spoke briefly in the interest of the Community Chest drive.

The following applicants were elected to membership in the Society: Dr. Charles J. Aria and Dr. R. A. Cosgrove, both of Jersey City; Dr. G. L. Bellina of North Bergen and Dr. W. V. Harz of Bayonne.

Names of the following applicants for membership were referred to the Board of Censors: Drs. Milton Blum, V. R. Campana, Robert Rubenstein and Benjamin Starr, all of Jersey City; Dr. S. S. Boyers of Union City; Dr. Thomas P. Gleason of Bayonne; Dr. C. R. Kanengiser of North Bergen and Dr. Sidney Woltz of Weehawken.

Dr. J. William Hinton, Associate Attending Surgeon at the New York Post-Graduate Hospital, spoke on "Evaluation of Experimental and Clinical Data in Thyroid Disease". The paper was discussed from the surgical point of view by Dr. R. B. Lobban; from the medical point of view by Dr. A. E. Jaffin. Other discussants included Dr. C. E. McNenny, Dr. Nicholas Alter and Dr. W. Barbarito. Dr. Hinton closed the discussion and the meeting was adjourned at 11 p.m.

MERCER COUNTY

A. Dunbar Hutchinson, M.D., Reporter

The *Mercer County Medical Society* met at Trenton October 8, President Cox presiding.

The regular order of business was suspended, and the Society being honored by the presence of President-Elect Elias J. Marsh, M.D., the President invited Dr. Marsh to speak.

Dr. Marsh gave in detail a most interesting account of the several outstanding activities planned in the program for the year created by State President Lewis.

Emphasis was placed upon the Medical Service Plans, local society members as speakers (instead of outside speakers), original papers from local society members for publication in the *Journal*, and hospital relationships.

Dr. Marsh stated that the numerous committee activities throughout the state indicated that the medical profession is alert and actively engaged in progressive measures tending to enlarge the scope of medical provision for all classes of humanity.

Mr. William C. Brown, Narcotic Inspector of the

Bureau of Federal Narcotics, then addressed the society on narcotic regulations, giving in detail several of the more important rules governing the administration of narcotics, many of which are frequently ignored, not in willful disregard but simply as a matter of indifference.

Several interesting incidents were related relative to the tracing of addicts, their habits, routine and final disposition. Mr. Brown displayed specimens of crude drugs, detailing many items of information generally unknown or unheard of regarding their uses.

Considerable interest was manifested by the numerous questions propounded by the members; many pertinent facts were further brought out by the answers submitted by Mr. Brown.

The application of George W. Irmisch, M.D., Resident Physician to Mercer Hospital, was favorably reported by the Membership Committee. Dr. Irmisch was then formally elected to associate membership.

The applications of Drs. Bergsma, Joseph Cohen, Edward G. Rowland and E. P. Sacks-Wilner were read and referred to the Membership Committee.

The Entertainment Committee was authorized to arrange for the Annual Banquet in November.

President Cox appointed the following Nominating Committee: Drs. R. J. Cottone and W. G. Rainey, for one year; Drs. William C. Ivins and J. N. Zimskind for two years, and Drs. F. E. Proctor and A. F. Moriconi for three years.

MIDDLESEX COUNTY

C. I. Hutner, M.D., Reporter

The October meeting of the *Middlesex County Medical Society* was held at the Roosevelt Hospital, Metuchen, N. J., October 15, 1941, and was called to order by Dr. R. J. Faulkingham, President. The minutes of the previous meeting, read by Dr. William E. Sherman, Secretary, were approved.

The application of Dr. Joseph C. Vargyas, 116 New Street, New Brunswick, was accepted and he was elected to associate membership.

The Health Office of the National Youth Administration of New Jersey sent the Society the following names to be approved as medical examiners for the N.Y.A.: Dr. Gerald Miller of Cranbury, Dr. Ruth Stephenson of New Brunswick and Dr. Samuel Miller of New Brunswick.

Drs. Stephenson and Samuel Miller were approved by the society. A communication will be sent the Mercer County Medical Society to see if Dr. Gerald Miller of Cranbury is a member of that society. If he is, the communication will be referred to them.

A letter was read from Dr. John H. Rowland thanking the County Medical Society for its expression of sympathy in his late bereavement.

Dr. Kler introduced Dr. Kendall A. Elsom, Assistant Professor of Medicine at the University of Pennsylvania School of Medicine, who spoke on "The Modern Management of Some Gastro-Intestinal Problems". His paper dealt mainly with massive G.-I. hemorrhage; pyloric obstruction; intestinal obstruction, and ulcerative colitis.

A few salient remarks were then offered by Dr. Clark after which Dr. Elsom answered several questions put to him by members of the society.

Dr. Carr advised the society that the National Foundation for Infantile Paralysis will render any type of treatment necessary and provide consultation. If any member of the society is in need of any material or advice, he may consult Mr. Fitzgerald of Woodbridge.

Dr. Kler advised that the County Medical Society was invited to be the guests of the Pharmaceutical Society. Motion to accept the invitation for joint meeting to be held November 26, 1941, was carried.

Refreshments were then served in the cafeteria.

MONMOUTH COUNTY

Murray Woronoff, M.D., Reporter

The regular meeting of the *Monmouth County Medical Society* was held on September 24, 1941, at the Berkeley-Carteret Hotel at Asbury Park. The guest was Dr. Chester R. Brown, who spoke on "Prematurity". He presented a difficult subject very well in the time allotted him. An interesting discussion followed his talk and the movie on prematurity which he presented.

Our county mourned the loss of two of our esteemed members:

Dr. Warren H. Fairbanks of Freehold, 1884—1941, Medical Director of Allenwood Sanatorium.

Dr. Joseph W. Wiener, 1901—1941, Chief Cardiologist, Fitkin Memorial and Monmouth Memorial Hospitals.

Their passing leaves a gap hard to fill.

MORRIS COUNTY

Wilbur M. Judd, M.D., Reporter

The decision to combine the post-graduate educational work with the regular meetings of the *Morris County Medical Society* was adjudged most successful October 16, 1941, when nearly eighty physicians met at Greystone Park to hear Dr. Hugo Roesler, Cardiologist for the Department of Medicine and Associate Professor of Roentgenology, Temple University Medical School and Hospital, give the first of the series of six lectures planned for the year.

Dr. Teller, our President, introduced Dr. Roesler, who held our attention with a most practical and clearly outlined discussion of "Bedside Diagnosis and Treatment of Disturbances of the Rate and Rhythm of the Heart, Including a Discussion of Dizziness and Fainting on a Circulatory Basis", with lantern slides for demonstration and illustration. He particularly stressed the importance of ruling out anxiety, anemia, thyrotoxicosis, posture, low-grade infections, and the effects of such drugs as benzedrin, sulphate and nitroglycerin as factors producing tachycardia and palpitation. He also outlined some practical methods and suggestions in the use of digitalis and quinidin sulphate.

Dr. Stewart and Dr. Young briefly discussed the subject.

Dr. Hawkes, of the Board of Trustees of The Medical Society of New Jersey, was introduced.

Dr. Teller announced that the next meeting would be held at Greystone Park November 13, 1941, at which time Chester I. Ulmer, M.D., Chairman of the Joint Committee on Professional Relations, and Robert P. Fischelis, Ph.D., Editor of the New Jersey Formulary, will be present to discuss this important work.

OCEAN COUNTY

L. W. Falkinburg, M.D., Reporter

A business program occupied the *Ocean County Medical Society* at its regular monthly meeting at Paul Kimball Hospital, Lakewood, on September 10, 1941. The meeting was called to order by Dr. Ivory, the President, and the minutes of the previous meeting were approved.

The Secretary read the communications he had received, including an appeal from the Ocean County Health Department. This was a request for speakers on "Nutrition". Drs. Bunnell and Pecora were selected to speak on this topic.

A number of scientific problems were briefly discussed, but there was no formal scientific address.

PASSAIC COUNTY

Irving Okin, M.D., Reporter

The regular monthly meeting of the *Passaic County Medical Society* was held Thursday evening, October 9, 1941, at School No. 13, Paterson. Dr. Sigurd W. Johnsen, President, presided.

The following new members were elected:

Active Membership—

Dr. Sydney J. Baxt, Paterson

Dr. Albert J. Blake, Paterson

Dr. Arthur C. Lawrence, Lincoln Park

Dr. Michael A. Ogden, Passaic

Associate Membership—

Dr. John G. Lima, Paterson

Courtesy Membership—

Dr. Ottavio Pellitteri, Warren Point

Applications for one active and three associate memberships were read as having been received.

An amendment to the Constitution was read, to be voted on at the next meeting in November. This amendment provides that any medical doctor licensed by the State of New Jersey may be eligible for membership to the Passaic County Medical Society. This amendment is to replace the present requirements which limit membership only to graduates of Class A medical schools.

The first speaker was Mr. O. N. Auer, President of the New Jersey Hospital Association. His topic was "Hospital Relationships—the Doctor and the Public". He pointed out that the doctor, the hospital and the public are inter-related very closely and that the desires of the public are: good, scientific care at moderate cost. The public does not understand the problems of the hospital and the doctor and Mr. Auer feels that lack of information has been the cause of much misunderstanding. He suggested that the hospital should publicize its activities more and that the doctors help do this.

He listed the following publicity channels:

1. Woman's Auxiliaries.
2. News bulletins and leaflets.
3. Satisfied employees spread good will.
4. Coöperation with local press.
5. Speakers on hospital activities at service clubs.
6. Coöperation of the hospital with the Fire and Police Departments.
7. Radio addresses.
8. Demonstrations of hospital activities.
9. Annual report.

Dr. Henry B. Decker, Chairman of the Committee on Hospital Relationships, Medical Society of New Jersey, pointed out that as medicine has developed, expensive apparatus has been necessary and hospitals satisfied this need. He felt that perhaps governing boards do not understand problems of the medical staff, while individual physicians tend to think of their own activities. He asked for closer coöperation between the governing boards and the medical hospital staff. He spoke of a survey done by his committee a year ago, in which ninety hospital By-Laws have been analyzed. They found that 60 per cent of clinic patients had been referred by private doctors. He suggested that doctors rotate their services in dispensaries so that a young man would have a complete all-around training in various departments.

The attendance at the meeting was small but there was a lively discussion.

The meeting then adjourned.

POST-GRADUATE COURSES OF THE SOCIETY

Reported by W. W. Hall, M.D., Chairman of Committee on Graduate Education

Following is the program of lectures to be given by the Passaic County Medical Society:

X-Ray (at St. Joseph Hospital, Paterson)—

Oct. 21—"The Diagnosis of Pulmonary Lesions", Earl L. Warren, M.D.

Nov. 18—"The Diagnosis of Heart Lesions", J. J. Szymanski, M.D.

Nov. 25—"The Diagnosis of Gastro-Intestinal Lesions", Jacob Roemer, M.D.

The first lecture was held October 7 at St. Joseph Hospital, on "The Value of the Fluoroscope in the Examination of the Patient", given by Harry N. Golding, M.D., and A. J. Delario, M.D. It was attended by a large number of physicians. This has necessitated the new sessions in fluoroscopic demonstrations, limited to five doctors, each Monday at St. Joseph Hospital.

Dermatology—

"Clinical Demonstration of the More Common Skin Diseases and Their Treatment."

Oct. 9—Paterson General—Dr. G. K. Tweddell.

Oct. 23—Barnert Hospital—Dr. J. J. Greengrass.

Nov. 13—St. Joseph Hospital—Dr. R. J. McDonald.

"Recent Advances in Diagnosis and Treatment."

Nov. 27—Paterson General—Dr. Charles Mitchell.

The attendance for the first lecture held October 9 was very gratifying.

SALEM COUNTY

L. C. Hummel, M.D., Reporter

Our first fall meeting was held September 19, 1941, at the DuPont Country Club, Pennsgrove, N. J., Dr. E. E. Evans presiding.

A timely paper on anterior poliomyelitis was presented by Dr. C. Fred Becker of Camden, who reviewed the pathology, symptoms, diagnosis and methods of treatment, giving us a comprehensive, up-to-date picture of the subject.

A speaker from the New Jersey Hospital Service Plan gave a resume of the opportunities offered by that organization and invited our Society to enter as a group.

A letter from Dr. J. F. Quigley was read which highly commended Senator Summerill and Assemblyman Kern for their splendid coöperation and support of all medical legislation in which the society was interested during the past year. We were proud to feel that the representatives from our county were back of us one hundred per cent.

Due to the transfer of Dr. Norwood from the DuPont plant at Deepwater, N. J., to the plant in Indiana, the vice-presidency was left vacant and Dr. F. L. Perry of Woodstown, N. J., was elected to fill the office for the coming year.

Dr. Francis Sayres of Pennsgrove and Dr. Charles Savage of Zeigler Tract made application for membership.

About twenty members enjoyed dinner at the club following the meeting.

UNION COUNTY

Edward G. Bourns, M.D., Reporter

The annual Fall Outing of the *Union County Medical Society* was held September 24th at the Shackamaxon Country Club at Westfield. We are very proud to announce that there seems to be continued improvement in the type of golf exhibited by the members; highest gross score last spring was 130 whereas this fall it was down to 119. (For a modest stipend the reporter has agreed to omit the name of the owner of this effort.) Two tournaments were run, a kickers and a low gross. The latter was won by Dr. Walter Radcliffe, a guest of Dr. William Wuester. He turned in a 75. However, it is rumored that Dr. Radcliffe has his living-room cluttered with prizes so that the rest of us should not feel too badly. In the kickers tournament the following doctors received prizes of a set of golf balls: J. M. Lyerly, J. E. Runnells, E. G. Brittain, David Stewart, E. W. Lance, Douglas Kramer, Joseph Stybel.

Following a very nice dinner the meeting was called to order by Dr. Lorrimer Armstrong. The following guest speakers spoke briefly: Dr. Thomas K. Lewis on the Medical Service Administration and plans for expanding it through local communities and possibly through several federal agencies; Dr. LeRoy Wilkes, a few words on current medical problems; Dr. Watson Morris elaborated on the plans of the Fall Clinical Conference which is being presented by Union County this year. Other guests were Dr. Charles Robbins of Newark and Mr. Ray Corcoran, Westfield.

Following the routine business of the evening, door prizes, contributed by many commercial firms and druggists, were won by the following doctors: Drs. Walter Radcliffe, R. C. Peters, H. S. Murphy, Charles Spier, S. H. Davis, M. M. Osher, E. J. O'Brien, Harry Hansen, William Wuester, H. E. Abel, Lorrimer Armstrong, E. G. Bourns, H. H.

Bowles; also Louise Rogers and Mr. Ray Corcoran. It may fall to your attention in perusing the above list of winners to notice that the President of the County Medical Society and the reporter both managed to win door prizes. After all, there is no point in being on the committee unless one can pick up a drop of gravy here and there.

BOOKS RECEIVED FOR REVIEW

MANUAL OF BANDAGING, SPLINTING AND STRAPPING. By Augustus Thorndike, Jr., M.D., F.A.C.S. Pp. 144 with 117 engravings. Phila., Lea & Febiger. 1941. \$1.50.

INTERVERTEBRAL DISCS, with special reference to rupture of the annulus fibrosus with herniation of the nucleus pulposus. By F. Keith Bradford, M.D., and R. Glen Spurling, M.D. Pp. 158. Springfield, Charles C. Thomas, Publisher. 1941. \$4.00.

SULFANILAMIDE AND RELATED COMPOUNDS IN GENERAL PRACTICE. By Wesley W. Spink, M.D. Pp. 256. Chicago, Year Book Publishers, Inc. 1941. \$3.00.

INFANTILE PARALYSIS; a symposium delivered at Vanderbilt University, April, 1941. Pp. 239. New York, National Foundation for Infantile Paralysis, Inc. 1941.

DISEASES OF THE NAILS. By V. Pardo-Castello, M.D. 2d ed. Pp. 193 with 98 illus. Springfield, Illinois, Charles C. Thomas, Publisher. 1941. \$3.50.

ESSENTIALS OF GENERAL SURGERY. By Wallace P. Ritchie, M.D. Pp. 813. St. Louis, C. V. Mosby Company. \$8.50.

CLINICAL IMMUNOLOGY, BIOTHERAPY AND CHEMOTHERAPY IN THE DIAGNOSIS AND TREATMENT OF DISEASE. By John A. Kolmer, M.S., M.D., Dr.P.H., Sc.D., LL.D., L.H.D., F.A.C.P., and Louis Tuft, M.D. Pp. 941. Philadelphia, W. B. Saunders. 1941. \$10.00.

SYNOPSIS OF THE PREPARATION AND AFTERCARE OF SURGICAL PATIENTS. By Hugh C. Ilgenfritz, A.B., M.D., and Rawley M. Penick, Jr., Ph.B., M.D., F.A.C.S., with foreword by Urban Maes, M.D., D.Sc., F.A.C.S. Pp. 532. St. Louis, C. V. Mosby Co. 1941. \$5.00.

1941 YEAR BOOK OF PUBLIC HEALTH. Ed. by J. C. Geiger, M.D., Dr.P.H. Pp. 544. Chicago, Year Book Publishers. 1941. \$3.00.

TRAUMA AND DISEASE. Ed. by Leopold Brahdy, B.S.,

M.D., and Samuel Kahn, B.S., M.D. 2d ed. Pp. 655. Philadelphia, Lea & Febiger. 1941. \$7.50.

COMPLETE WEIGHT REDUCER. By C. J. Gerling. Pp. 246. New York, Harvest House. 1941. \$3.00.

CANCER OF THE FACE AND MOUTH; diagnosis, treatment, surgical repair. By Vilray P. Blair, M.D.; Sherwood Moore, M.D., and Louis T. Byars, M.D. Pp. 599. St. Louis, C. V. Mosby Co. 1941. \$10.00.

ESSENTIALS OF OCCUPATIONAL DISEASES. By Jewett V. Reed, B.S., M.D., F.A.C.S., and A. K. Harcourt, B.S., M.D. Pp. 225. Springfield, Charles C. Thomas. 1941. \$4.50.

PREMATURE INFANT; its medical and nursing care. By Julius H. Hess, M.D., and Evelyn C. Lundeen, R.N. Pp. 309. Philadelphia, J. B. Lippincott Co. 1941. \$3.50.

DISEASES OF THE BLOOD AND ATLAS OF HEMATOLOGY, with clinical and hematologic descriptions of the blood diseases including a section on technic and terminology. By Roy R. Kracke, M.D. 2d ed. Pp. 692, 54 color plates. Philadelphia, J. B. Lippincott. 1941. \$15.00.

OPERATIVE SURGERY, including anesthesia, pre- and post-operative treatment; principles of surgical technic; blood transfusion and abdominal surgery. Ed. by Frederic W. Bancroft, A.B., M.D., F.A.C.S. Pp. 1102. New York, D. Appleton-Century. 1941. \$10.00.

DEVELOPMENTAL DIAGNOSIS. By Arnold Gesell, M.D., and Catherine S. Armatruda, M.D. Pp. 447, illus. New York, Paul B. Hoeber, Inc. 1941. \$6.50.

THE TRAUMATIC NEUROSES OF WAR. By Abram Kardiner, M.D. Pp. 258. New York, Paul B. Hoeber, Inc. 1941. \$3.50.

SHOCK TREATMENT IN PSYCHIATRY. By Lucie Jessner, Ph.D., M.D., and V. Gerard Ryan, M.D. Pp. 155. New York, Grune & Stratton, Inc. 1941. \$3.50.

CHARRED DOCUMENTS MAY BE DECIPHERED by the use of a process in which a 25 per cent solution of chloral hydrate in alcohol is applied several times to the document which is dried at 60 degrees C. between each application until a mass of chloral hydrate crystals forms on the

surface. Ten per cent glycerine is then added to the chloral hydrate and applied to the document, which is then dried as before, and may then be photographed. It has proved satisfactory for type-written, printed and handwritten matter.

BOOK REVIEWS

Treatment of Diabetes Mellitus. By Elliott P. Joslin, M.D. 7th ed. Pp. 783 with 117 tables. Philadelphia, Lea & Febiger. 1940. \$7.50.

This is still an essential, standard text on the subject. It is complete in all aspects of the treatment of diabetes mellitus. The development of therapy is carefully outlined to show clearly how the authors arrived at their present method. Adequate attention is paid to other dietary treatments and their indications. The authors enumerate the reasons for their preference for protamin zinc insulin. The concept of a new era in treatment with the long-acting insulin is original with them.

The text is enriched by references and illustrative cases—of which Joslin and his associates have an inexhaustible source. The reviewer had occasion to refer to many of the citations which, in themselves, augmented the value of the reading matter.

Joslin emphasizes the contributions of Drs. Root, White, Marble and McDaniel. This gives the book the advantages of the multiple author system of writing medical literature. Even a single subject like diabetes mellitus has many facets which demand special scrutiny and its ramifications into the many fields of internal medicine make it complicated enough to justify this system.

The chapter on "Allergy and Diabetes" by Dr. McDaniel is an innovation. Nearly half the book is taken up with the complications and concurrent diseases found with diabetes mellitus. The teaching methods for prevention of complications, particularly coma and acidosis, cannot be read too often.

The doctor alone cannot treat the patient, says the author. He outlines methods of group instruction and mentions camps for diabetic children.

Parts of the text still suffer noticeably from a lack of conciseness, a fault of most American writers, especially when compared with the English. However, the parenchyma, or active tissues of the book, makes up a well-functioning organ of medical teaching and knowledge.

EVERETT O. BAUMAN, M.D.

Infantile Paralysis—Anterior Poliomyelitis. By Philip Lewin, M.D. Pp. 372. Philadelphia, W. B. Saunders Co. 1941. \$6.00.

This large book on epidemic poliomyelitis covers all points of view with special emphasis on the instruction of general practitioners and those associated with them in the care of the poliomyelitic patient. The author insists that "no major deformity should be allowed to occur".

Lewin discusses the treatment of the poliomyelitic patient in the acute, convalescent and chronic stages. The chapter on treatment illustrates numerous types of braces. The author feels that "standardization of braces is essential for quality but individualization is imperative for every patient".

Howard J. Shaughnessy, Ph.D., contributed chapters on etiology, epidemiology and predisposing fac-

tors, while Sidney O. Levinson wrote the chapters on pathogenesis and pathology.

The book is well illustrated, especially the chapters on treatment, both preventive and operative; and the bibliography is inclusive. Although written primarily for the general practitioner, this text can be a useful reference book for the orthopedic specialist.

TOUFICK NICOLA, M.D.

Techniques of Conception Control. By Robert Latou Dickinson, M.D., and Woodbridge Edwards Morris, M.D. A practical manual issued by the Birth Control Federation of America, Inc. With 50 illustrations. Baltimore, Williams & Wilkins Co. 1941. \$.50.

This brochure contains complete information on the subject including the experiences of the foremost practitioners of this specialty with a critical evaluation of the methods and instructions for uses. The illustrations are excellent. It is reasonably priced, considering the amount of material it contains.

Electrocardiography; Including an Atlas of Electrocardiograms. By Louis N. Katz, M.D. Pp. 580. Philadelphia, Lea & Febiger. 1941. \$10.00.

Dr. Katz has written a book which is a "must" for every man who wishes to do electrocardiography. As was to be expected, from the physiologic point of view, there is nothing that could be more thorough on this subject. However, there is a definite lack of "clinical feeling" in certain portions of the volume. This deficiency, however, need not be regarded as a serious drawback, when the work is considered as a whole, because of the uniform excellence of the rest of the monograph.

The beginner in electrocardiography may find the book the least bit technical when he attempts to read it for the first time. With diligent application and studious regard for the text, I feel certain that he will be adequately rewarded by a knowledge of electrocardiography which will be of such a solid nature, that no tracing, be it ever so intricate, will shake him.

Every reader of this ambitious work will be greatly benefited by the introductory chapters on the basic concepts of electrocardiography, the pitfalls and the principles underlying the various types of instruments used, since this is the type of thing that gives the mind that little jog needed to remind it that the science of electrocardiography still has some wide gaps to fill.

In summary, therefore, we may safely say that this is a book that every man interested in cardiology should have, and should read at frequent intervals to keep himself alert. But, a word of caution must be added, in that Dr. Katz at times reads more into his electrocardiograms than most clinicians would venture to do.

AARON E. PARSONNET, M.D.

Primer for Diabetic Patients; an outline of treatment for diabetes with diet, insulin and protamin-zinc insulin including directions and charts for the use of physicians in planning diet prescriptions. By Russell M. Wilder, M.D. 7th ed. Pp. 184. Philadelphia, W. B. Saunders. 1941. \$1.75.

After reading Wilder's excellent scholarly text on diabetes mellitus, his "Primer for Diabetic Patients" is somewhat disappointing. This is almost a simplified outline of the larger text in many ways; yet perhaps not simplified enough. The patients of the Rochester clinic must be above the average in intelligence if this book is meant for their reading. The title "for diabetic patients" is, in part, a misnomer, since some chapters of this book are definitely meant for the physician. The material on diabetic acidosis is definitely a first aid treatise for the general practitioner.

The inclusion of a nomogram in a book for patients is a questionable addition. Unfortunately, also, there are some definite errors in calculations of food values, which might be ascribed to typographic errors.

However, if the text is used by a somewhat selected group of patients, its completeness and the wealth of information on the complications of diabetes are of definite value. The listing of questions for study at the end of chapters is a good idea.

EVERETT O. BAUMAN, M.D.

Exercises in Electrocardiographic Interpretation.

By Louis N. Katz, M.D. Pp. 222. Philadelphia, Lea & Febiger. 1941. \$5.00.

This is a companion volume to "Electrocardiography", and is a glorified enlargement of a pamphlet, 26 electrocardiographic plates, published by the University of Chicago Press, but it has not been improved by its emergence from the chrysalis state. The original was clear, concise and devoid of controversial curves. This volume, however, seems to revert to the misty dawn of electrocardiography when a mere tracing was supposed to be an omniscient cardiac diagnostician. We know now that an electrocardiogram without the aid of a complete and careful clinical work-up of the patient cannot be used to make a diagnosis. Yet, Dr. Katz, time after time, shows tracings into which he reads diagnoses that no one would dare to make without a clinical history. This type of thinking will so confuse the embryonic electrocardiographer, who will unquestionably try to use this volume as a fountainhead of comparison, that in the long run, he will never venture to call a tracing normal. This is best demonstrated by reading pages 32 and 33, pages 36 and 37, case 14, p. 47; case 17, p. 53; case 28, p. 79; case 34, p. 91, to list but a few examples. Many of these curves, I am certain, would be dismissed as insignificant electrocardiographically, and yet Dr. Katz reads into them so much that we are reminded of Galen and his teleologic explanation of every physiologic phenomenon. This is an unfortunate and needless companion-piece to an excellent book and will not, I hope, detract from Dr. Katz's other really exhaustive and excellent text-book.

AARON E. PARSONNET, M.D.

Dr. Colwell's Daily Log for Physicians, a blank book for the financial record of the physician's daily business with monthly summaries. Price \$6.00. Colwell Publishing Co., Champaign, Ill.

Once again this highly efficient, silent secretary is now made available to the medical profession. The Daily Log has long enjoyed a reputation for its compactness and simplicity as a combined appointment book, business summary, surgical and narcotic record, and daily desk companion. It provides a page for each day of the year, with space for indicating either advance appointments or the hour at which each patient was seen, space for entering the type of service rendered, the charge made, the payment made and balance due.

Following the page for the last day of each month is a general utility record and a page for entering lists of narcotics dispensed, operations performed, and taxes paid. A handy set of obstetric records including a "waiting list", a space for listing notifiable diseases, a special page for reporting deaths, and a financial summary sheet with space for the "spread of expense" conclude the volume.

The book is so bound that it is possible to unscrew the binder posts and insert additional pages or remove unwanted pages. The paper is of good quality and the rulings are printed in restful green lines.

In view of the difficulties which so many doctors experience in the proper recording of their business accounts, this Daily Log should be a useful adjunct to medical practice. With sky-rocketing income tax rates it behooves the physician to be meticulously accurate in the recording of his income and his deductible expenses. The Daily Log is a useful aid to this end.

Cerebrospinal Fever. By Denis Brinton, M.D. Pp. 163. Baltimore, Wm. Wood-Williams & Wilkins. 1941. \$3.00.

The peculiar liability of soldiers to meningitis lends this book an especial timeliness. Brinton points out that overcrowding always precedes a severe epidemic of cerebrospinal fever, and that such factors as poor ventilation tend to accelerate the spread of the disease. Such practical military-medical techniques as spacing between beds in barracks are carefully considered in this compact monograph. The author augments the usefulness of his text by discussing in vivid detail such concrete questions as to whether a patient should be awakened during the night to receive medication, how to administer the drugs in spite of vomiting, or how to calculate a dosage formula. More than one-quarter of the volume is devoted to treatment. Chemotherapy alone is considered "sufficient", and the author prefers sulfapyridin to the other sulfonamids. However, serum treatment (though stamped as obsolete, expensive and ineffective) is objectively discussed.

The book is rounded out by a number of intensely practical chapters on diagnosis, epidemiology and prognosis. The entire monograph is a crisp, usable handbook for any practitioner who undertakes the responsibility of treating a patient stricken with cerebrospinal meningitis.

HENRY A. DAVIDSON, M.D.

Abdominal Surgery of Infancy and Childhood. By William E. Ladd, M.D.; Robert E. Gross, M.D. Pp. 455. Philadelphia, W. B. Saunders Co. 1941. \$10.00.

This excellent text sets forth in a readily understandable, adequately illustrated way, the diagnosis and treatment of abdominal disorders in childhood based on a careful review of the embryology and pathology of the condition. The section on congenital malformations of the intestinal tract should be read by all surgeons, obstetricians and pediatricians. It is the only collection of such cases to be found in the American literature.

There is an ample bibliography. Controversial subjects are fully discussed, and a definite stand is taken on many of these controversies, based on the wide experience of the authors.

The value of the book can be appreciated if one understands something of the authors. William Ladd is undoubtedly the peer of children's surgeons, a masterful technician with an insatiable curiosity. As professor of children's surgery at Harvard Medical School, he has had a vast experience backed by the resources of the pathology and x-ray departments. Collaborating with him in this book is Robert Gross, a young surgeon equipped with an extensive ground work in pathology and experimental surgery. Gross may be more readily remembered as the first surgeon successfully to close off a patent ductus arteriosus in a child.

Together they have given us a book that all doctors attending infants and children should read and re-read when a baffling diagnostic problem arises.

ROBERT E. JENNINGS, M.D.

Body Mechanics in Health and Disease. By Joel E. Goldthwait, M.D., F.A.C.S., LL.D.; Lloyd T. Brown, M.D., F.A.C.S.; Loring T. Swaim, M.D.; John G. Kuhns, M.D., F.A.C.S. Philadelphia, London, Montreal: J. B. Lippincott Company, 1941. xiv, 316 pages. Price \$5.00.

The material in this book is based on cases observed by the authors, and presents a continuing study and reevaluation of principles as the study progresses. In this third edition has come a change in emphasis, with the recognition that prevention plays the dominant rôle in the elimination of chronic disease. This edition follows the same general plan as the previous ones. But in addition to a discussion of the problems of chronic medicine and systemic diseases, body types and mechanics and their public health aspects, there has been added a chapter on developmental deformities, as well as a special chapter on angina pectoris and postural emphysema related to obesity, contributed by Dr. William J. Kerr.

The authors contend that most chronic diseases are associated with a wrong use of the body. Good body mechanics is not a part of the neuromuscular inheritance of the individual; it is the result of conditioned reflexes, and these must be developed from earliest childhood. For those who have already acquired faulty posture, treatments and special exercises are outlined.

HENRY H. KESSLER, M.D.

Conditioned Reflexes and Psychiatry. By I. P. Pavlov, translated by W. H. Gantt, M.D. Pp. 199. New York. International Publishers. 1941.

In spite of all our talk about psychosomatics, the gap between mind and matter is still unbridged. It is all very well to say, for example, that worry causes hyperacidity, which in turn precipitates or re-opens a gastric ulcer—thus presenting a case of mind influencing matter. Such an explanation hastily skips the one vital link: exactly how did the worry cause the hyperacidity? The neurophysiologist retorts triumphantly: through a "mediation" of the sympathetic nervous system and consequent chemical changes. But the query has only been rephrased—not answered.

The distinguished physiologist, Ivan Pavlov, in this collection of lectures offers an explanation—not by explaining how mind influences matter, but by suggesting how material stimuli may influence mind. Thus he demonstrates by cold, objective laboratory experiment that it is possible to provoke a neurosis in an animal by using stimuli which are opposing in direction or too complex in content. He has similar ingenious explanations for the development of paranoid and obsessional traits, by reducing those traits to their psychologic elements, and then reproducing those elements by manipulating stimuli.

The book consists of sixteen lectures, with such challenging titles as "An Attempt to Understand the Symptoms of Hysteria Physiologically" or "A Physiologic Interpretation of Paranoia" or "The Fusion of the Subjective with the Objective". Since the lectures were given at varied times and places, the volume is not an integrated, serial whole, and there is naturally a certain amount of repetition and unevenness.

The text should be of compelling interest to the neuropsychiatrist and physiologist; and it will be stimulating to any physician who has ever given thought to that one last problem of all: the material roots of the human mind. Not that Pavlov solves the problem. But at least he furnishes nourishing food for thought about it.

HENRY A. DAVIDSON, M.D.

Cardiac Clinics; A Mayo Clinic Monograph. By Frederick A. Willius, M.D. Pp. 276. St. Louis, C. V. Mosby Co. 1941. \$4.00.

This is a collection of articles published by Dr. Willius and his associates at the Mayo Clinic, which appear at frequent but irregular intervals in the "Proceedings of the Staff Meetings of the Mayo Clinic". The man in search of cardiologic tidbits will always find these articles timely and practical. A collection of such lectures will have a special appeal to those physicians who are in the habit of getting their information while they run.

Although this volume will not answer any of the burning questions in cardiology, it will make a useful addition to the limited medical library of the general practitioner.

AARON E. PARSONNET, M.D.

Start Today; Your Guide to Physical Fitness. By C. Ward Crampton, M.D. Pp. 224. New York, A. S. Barnes & Co. 1941. \$1.75.

In this interesting book, the author uses top-notch salesmanship to introduce a series of worthwhile exercises. For this reason they should have more appeal than usual.

The reviewer sincerely hopes that the readers of this work will not consider reading the exercises equivalent to doing them.

It should be remembered that the text is written in colloquial fashion and cannot, therefore, be used as a scientific reference.

Essentials of Electrocardiology, for the student and practitioner of medicine. By Richard Ashman, Ph.D., and Edgar Hull, M.D. 2d ed. Pp. 373. New York, The Macmillan Co. 1941. \$5.00.

The second edition of this volume, of which the first appeared in 1937, is larger by many pages. It is well printed and profusely illustrated. The electrocardiograms, however, with very few exceptions, are poorly selected and badly reproduced. The plan of the book is haphazard and confusing and in many instances repetitious. But it is no worse than the dozen or so text-books of similar nature which have made their appearance in the last couple of years.

AARON E. PARSONNET, M.D.

Developmental Diagnosis. By Arnold Gesell, M.D., and Catherine Amatruda, M.D. Pp. 447. Paul B. Hoeber, Inc. Price: \$6.50.

No heartache in medical practice is as poignant as that which arises out of errors in child welfare and child guidance. The physician who casually advises an eager couple to adopt a bright-looking child is shouldering a heavy responsibility. The doctor who assures a terrified mother that her baby will "grow out" of his apparent retardation in talking or walking may be unconsciously inflicting an exquisite cruelty on the trusting parent. In few other fields does the physician so badly need a dependable handbook.

For that reason, no practitioner whose work touches on child behavior should be without this readable manual. It is certainly an essential tool to the pediatrician, the psychiatrist, the orthopedist and the "family" doctor. Here is a clear, concrete analysis of the behavior patterns of normal children at every age level. The "tests" are set up in tabular form, profusely illustrated by line drawings, so that even the busiest practitioner can examine the child's behavior and compare it to the clearly listed scale of norms. Most of the tests are easily carried out, the equipment readily available, the instructions vividly written. Not that the measurement of a child's development is as simple as reading off a number on a weight-scale. But at least, the rich battery of "normal" responses at each age will give the practitioner some yardstick

for measuring the maturity of his patient. A more refined evaluation is the job of the specialist, of course. But the Gessell-Amatruda manual is written so that the non-expert can follow the instructions and get a clinically accurate, if scientifically rough, estimate.

The effects of head injury on the child's development, with a review of the methods for measuring this effect, are embodied in a highly practical section which ought to be absorbed by any physician who ever takes the witness stand to testify about head injury in children.

An interesting and hard-headed chapter entitled "Clinical Aspects of Child Adoption" will prove an eye-opener for practitioners called upon to give advice on this enormously important question.

The volume closes with an appendix in which are presented the exact techniques of preparing the equipment, performing the tests and recording the results.

"Developmental Diagnosis" is probably the most useful book in this field since Terman published his "Measurement of Intelligence" thirty years ago.

M. W. BERGMAN, M.D.

The Intervertebral Disc. With Special Reference to Rupture of the Annulus Fibrosus with Herniation of the Nucleus Pulposus. By F. Keith Bradford, M.D., and R. Glen Spurling, M.D. Springfield, Ill., Charles C. Thomas, 1941. 158 pages. Price \$4.00.

This monograph should go far toward clarifying the situation with respect to the etiology of low back pain and sciatica. In addition to recording their own observations, the authors have made an exhaustive analysis of the literature and have here included those studies that have been best authenticated by the most painstaking work. They especially emphasize the contribution of Mixter and Barr in demonstrating that a common cause of severe sciatic pain is nerve root compression resulting from disease of the intervertebral disc.

The greater part of the text is concerned with clinical and roentgenologic investigations and the findings in herniation of the nucleus pulposus. But the background material on the embryology, anatomy and physiology of the disc is fully covered and another chapter is given over to disc pathology and its bearing on many orthopedic problems. The writers emphasize the fact that other conditions may give similar clinical findings, and warn against attributing all sciatic pain to a herniation of the nucleus pulposus.

The most recent operative technique for lumbar laminectomy is described in full. But while more than 2000 patients have been operated during the past six years for herniation of the intervertebral disc in the United States alone, the writers point out that the final outcome will not be known for many years, that is, until there has been sufficient time to observe the effect of wear and tear on the essentially abnormal intervertebral disc.

HENRY H. KESSLER, M.D.

● THE BULLETIN BOARD ●

The next meeting of the Union County Medical Society will be held **November 12** at St. Elizabeth's Hospital, Elizabeth. The speaker, Dr. Norman Jolliffe, Bellevue Hospital, New York, will talk on "Recent Clinical Application of Vitamin Therapy".

. . .

The Burlington County Medical Society will hold its 112th Annual Meeting on Thursday evening, **November 13**, at 9:00 p. m. The feature of the evening will be a talk on "Hypertension and Nephritis" by Dr. Edward Weiss, Clinical Professor of Medicine, Temple University.

. . .

"Child Health in the Defense Program" will be the topic of the **November 13** meeting of the Essex County Medical Society to be held at 9:00 p. m., at 91 Lincoln Park (Academy of Medicine) in Newark. The speaker, Dr. Martha Eliot, is the Associate Chief of the United States Children's Bureau.

. . .

"Chest Diseases in Children" will be the subject of the second Chest Conference of the Essex County Medical Society's Lung Committee to be held at St. Michael's Hospital, Newark, at 12 noon, Thursday, **November 27**.

The Conference will be conducted by Dr. Harrold A. Murray. Dr. Bela Schick will be the guest speaker. All physicians are invited to attend.

. . .

Dr. Leonard G. Rowntree, Chief of the Medical Division of the Selective Service Administration, will speak before the Atlantic County Medical Society, Friday evening, **November 14**, at the Hotel Traymore, Atlantic City. All physicians are invited to attend.

. . .

"Office Gynecology" will be the subject of the talk to be given by Dr. H. E. Shipps of Delanco, who will speak to the Salem County Medical Society at its meeting in the Salem Tea Room, Salem, on Friday afternoon, **November 14**, at 4:00 p. m. The meeting will be followed by a dinner.

Dr. Robert G. Gillespie, psychiatrist to the British Royal Air Force, will deliver a series of Salmon Memorial Lectures.

He will speak at the New York Academy of Medicine on **November 17 and 18** at 8:30 p. m., and again in Philadelphia on **November 30** at 3:00 p. m. at the College of Physicians. He will discuss psychoneuroses with reference to the problem of human relationships.

. . .

A Symposium on Obstetrics will feature the next meeting of the Gloucester County Medical Society on Tuesday, **November 18**, at 9:00 p. m., at the Woodbury Country Club. Dr. Harvey B. Matthews of Brooklyn, Obstetrician to the Long Island College Hospital, will speak on "Prolonged Labor", and Dr. Arthur W. Bingham, Chairman of the Maternal Welfare Committee of The Medical Society of New Jersey, will discuss the Society's Maternal Welfare Program.

. . .

Monmouth County Medical Society will meet on Wednesday, **November 26**, at 9:00 p. m., at Buttonwood Manor, Matawan. Dr. A. H. Neffson of New York will discuss "The Management of Acute Laryngotracheo-bronchitis".

. . .

A series of unusual gastro-enterologic cases will be presented before the Gastro-Enterological Society at a meeting Monday evening, **December 1**, 8:30 p. m., at the Jersey City Medical Center.

The cases will be presented by Dr. Edgar Burke, Chief Surgeon of that hospital. The evening will be devoted to a discussion of the surgical problems of the small and large intestines.

Officers for 1942 will be elected at that meeting. All physicians are welcome to attend.

. . .

"Surgical Therapy in Lesions of the Large Bowel" will be discussed by Dr. L. K. Ferguson, Assistant Professor of Surgery, University of Pennsylvania, on Thursday evening, **December 2**, at 9:00 p. m., before the Camden County Medical Society, meeting at 725 Federal Street, Camden.

• THE BULLETIN BOARD •

Dr. I. Wright will deliver a talk on peripheral-vascular diseases before the Bergen County Medical Society on Tuesday evening, **December 9**, at the Hackensack Hospital.

A series of Case Presentations and Discussions has been planned for the meeting of the Passaic County Medical Society on Thursday evening, **December 11**, at 9:00 p. m., in Valley View Sanatorium, Paterson, N. J.

A regular business meeting of the Somerset County Medical Society will be held at the Nurses' Home of the Somerset Hospital at 8:30 p. m., Thursday evening, **December 11**.

Polio-myelitis will be discussed at the **December 18** meeting of the Morris County Medical Society, which will be held at the State Hospital, Greystone Park, at 8:45 p. m.

The principal speaker will be Dr. P. Stimson, Attending Physician at the Willard-Parker Hospital in New York.

Applicants for the examination being given by the American Board of Obstetrics and Gynecology are reminded that the written examination and review of case histories will be held on **January 3, 1942**. For further information, address Dr. Paul Titus, Highland Building, Pittsburgh, Pa.

The Physicians Casualty Association of America announces a reduction in premium

rates for health and accident insurance amounting to a dollar a year for every \$25.00 a week of insurance carried; thus the policy paying \$75.00 a week now costs \$3.00 a year less.

The New Jersey Welfare Council will hold its annual conference at Asbury Park on **November 13, 14 and 15**. The meetings will be at the Berkeley-Carteret Hotel. Physicians interested in the social aspects of medicine will find this an interesting and challenging program.

Rahway, N. J., is the home of Mr. Joseph Rosin, who has just been elected a member of the Pharmacopoeia Revision Committee. The Secretary of the United States Pharmacopoeia's Board of Trustees has characterized Mr. Rosin's election as "recognition of the invaluable contribution he has made toward the standardization of medicinal chemicals". Mr. Rosin is Chief Chemist of Merck & Company.

A prize of \$100.00, to be known as the Pelouze Award, will be presented by the American Neisserian Medical Society to the person under thirty-five years of age who, in the opinion of that organization, has made an outstanding contribution to the control of gonorrhea each year. Details can be secured by writing to Dr. Oscar F. Cox, American Neisserian Medical Society, 475 Commonwealth Avenue, Boston, Mass.

WHATEVER THE OUTCOME OF THE present war, we may be sure that disease will be the final victor, accounting for the largest number of victims and carrying on its deadly work long after the voice of the last gun has spoken. It has been said that the last war was exceptional in that for the first time the number of casualties from military action exceeded the number of victims of disease. That is emphatically not true when the victims of disease among civilians are taken into consideration. Every war produces conditions favoring the spread of disease, of which mass movements of populations is one of the most important. In preparation for war the strength of armies is increased by recruits from villages and agricultural districts as well as cities. The former fall ready victims to such diseases as measles and mumps, meningococcal meningitis, and the pneumonias.—Frank Boudreau, M.D., N. Y. State Jour. of Med.

"THE LAMENTABLE IGNORANCE OF THE lay public is one of the greatest of the many factors which take their toll of the average patient suffering from consumption. In England we do not openly avoid the consumptive when we meet him in the street as is the custom in Cyprus; but social ostracism takes other forms. The consumptive finds it difficult to find employment, irrespective of the extent of the disease. He has merely to let drop the information that he has had tuberculosis to find himself surrounded by a host of prejudices and fears. He may have the spirit of willingness to work and his disease may be relatively benign, but the misguided trend of public opinion operates against him. If he is a victim of social eviction the relapse will probably come even more speedily because of the absence of work which is his means of providing himself and his dependents with bread and butter, which mean life itself."—J. B. McDougall.

● PERSONAL ITEMS ●

Major C. W. Way, a Delegate from the Cape May County Medical Society, now stationed at Fort Dix, gave a military dinner to the Fort Dix Medical Officers on October 15 at the University Club in Philadelphia. Among the many State Society members present were: Col. F. J. Quigley, Union City; Major Millard Sewall, Bridgeton, and Major Robert Kilduffe, Atlantic City.

Dr. D. W. McCreight of the Monmouth County Medical Society has been called into service as a First Lieutenant, and is now at the Army Air Base in New Orleans.

Dr. Benjamin F. Broselow of Franklinville has opened an office at 19 Maple Avenue, Clayton, where Dr. Alfred G. Gillis formerly practiced. Captain Gillis is now in the service at Camp Lee, Virginia.

Dr. Jerome G. Kaufman of Newark, a member of the Essex County Medical Society, has been advanced to the position of Instructor in Medicine at the New York Medical College.

Dr. Jacob S. Wolfe of Bloomfield, N. J., a member of the Essex County Medical Society, was honored recently by citizens of his community with the designation "Bloomfield's Outstanding Citizen of 1941".

Dr. E. Earl Wentzell has entered active service and his office has been taken over by Dr. Blinn Buell, formerly of Binghamton, New York.

Dr. Thomas M. Thompson has moved from Pitman and accepted a position with the State Department of Health in Pennsylvania as Health Officer for three counties in that state.

Lieutenant J. Earl Wentzell, who is stationed at Camp Livingston, La., is on a short furlough at his home in Wenonah. Before returning to Camp Livingston he will take a special two months' training course at the Army Medical School at Carlisle, Pa.

The State Department of Education announces the appointment of Dr. W. G. Guthrie, a member of the Essex County Medical Society, as Director of Health and Physical Education of the State Department of Public Instruction. Dr. Guthrie succeeded the late Allen G. Ireland.

Announcement has been made of a new medical group in Boonton, to be known as "The Community Medical Group". The new office, which was opened last month, contains sixteen rooms. Members of the Group are Drs. A. J. Ward, C. H. Deichman, E. J. Luippold and D. P. Williams. The doctors in this Group are all members of the Morris County Medical Society.

The Jefferson Medical College of Philadelphia has a new Dean recently appointed to succeed Dr. H. K. Mohler, who died on May 16, 1941. He is Dr. William Harvey Perkins, Professor of Medicine of Tulane University, and a graduate of Jefferson Medical College.

EVERYBODY TALKS ABOUT PREVENTIVE medicine. But how many people are willing to seek it, much less to pay for it? Isn't it true that the "average" man balks at paying a dentist a small fee for a prophylactic examination, but rushes to pay him a larger sum for an extraction or a filling? Rural physicians report that they have great difficulty persuading patients to take injections to *prevent* poison ivy, but no trouble at all in *treating* persons who develop the rash.

One reason is that a toothache or a burning skin is dramatic and attention-arresting. Prevention is

abstract and dull-sounding. Yet we know that prevention is a real possibility, cure a speculation. And theoretically, the public knows it too.

So here's a real forum for propagandists. Instead of picturing the cost of sickness, let them portray the joys of health. Instead of underlining the size of the doctor's treatment bill, let them spotlight the cheapness of his preventive-examination. The doctor can't do all this. He would be charged with solicitation of patients if he did. But it's an opportunity for the articulate critics of present health conditions. If they must complain, here's their ideal target.

WOMAN'S AUXILIARY

COMING EVENTS

ATLANTIC COUNTY

November 14, 1941, 9 p. m.
Traymore Hotel, Atlantic City
Speaker: Mr. Leon Leonard, Assemblyman, Atlantic County
Subject: Legislation

BERGEN COUNTY

November 12, 1941, 7:30 p. m.
Swiss Chalet
Dinner dance with Bergen County Medical Society

BURLINGTON COUNTY

December 1, 1941, 8 p. m.
Residence: Mrs. E. H. Wyman, 100 West Pearl Street, Burlington
Business meeting and Christmas party

ESSEX COUNTY

November 24, 1941, 2 p. m.
Academy of Medicine, Newark
Business meeting and tea

GLOUCESTER COUNTY

November 18, 1941, 9 p. m.
Woodbury Country Club, Woodbury
Speaker: Miss Martha Fenimore
Subject: First Aid

HUDSON COUNTY

December 1, 1941, 2 p. m.
Y. W. C. A., Fairmont and Storms Avenue, Jersey City
Play: "The Kleptomaniac", cast of Auxiliary members
Christmas party

WARREN COUNTY

November 18, 1941, 1 p. m.
Warren County Hospital
Business meeting and card party, benefit Warren County Hospital
Luncheon

THE BULLETIN

The first issued of "The Bulletin" has been received by those Auxiliary members who are wise enough to realize that in order to serve their organization intelligently they must be

cognizant of the activities of the Auxiliary. Join the ranks of the informed. Send a dollar for one year's subscription to Mrs. Samuel H. Jessurun, 613 High Street, Newark.

PUBLIC RELATIONS COMMITTEE

Your Chairman has had several meetings with the Public Relations Committee of The Medical Society of New Jersey. One was a luncheon session with our President, Mrs. Carlander. On September 26 a conference of the Public Relations Committee chairmen was held at the Executive Office in Trenton. Dr. Henry A. Davidson presided, suggesting possible procedures for the projects approved by the Public Relations Committee and the Advisory Committee of the Woman's Auxiliary. Fourteen women were present and eight counties were represented. After this conference, the ladies were the guests of Mrs. George Sommer, President of the Mercer County Auxiliary, for luncheon. Mrs. Carlander and Mrs. Hornberger were present at the conference.

The work of the Public Relations Committee parallels the program set up by the program chairman, but the outline suggested by the Public Relations Committee deals with outside organizations such as lay clubs, P. T. A.'s, etc. We as Public Relations Committees desire to place authentic information about the Medical Society and what it has to offer to lay organizations.

You may say how can this be done? Well, here's how:

1. Soliciting speakers for Women's Clubs and similar lay organizations. Auxiliary members who belong to such groups are urged to inform the Program Chairmen of these organizations that the Medical Society is in a position to supply speakers.

2. Scripts are available from the Executive Office. These may be used for health columns in lay club magazines.

3. Moving pictures are excellent attractions at meetings at lay clubs. For information as to how these and exhibit material may be obtained, write to your State Chairman.

4. All Auxiliary members may take part in clipping items of interest to Organized Medicine from the newspapers of their community.

5. The A. M. A. will probably have a nation-wide radio program this year and it will be another project in which the Auxiliaries may participate.

Your State Chairman is at your service and will be happy to serve you. The Public Relations Program will appear in the Year Book of the Auxiliary. Please read it and put it into action.

MRS. DON AGARD EPLER,
Public Relations Chairman.

"B" Is for Bergen and Burlington Counties

These articles, written by Presidents of County Auxiliaries, are published each month and describe the procedures, aims and pet objects of the County Auxiliaries.

BERGEN COUNTY

Members of the Bergen County Medical Society Auxiliary are looking forward to another successful year.

A Year Book has been edited and sent to each member and to prospective members for the purpose of developing an informed membership and with the hope of interesting possible new members. The volume includes a list of Officers, Chairmen of Committees and Auxiliary members, as well as the complete program for the year.

Our Program Chairman has planned a most interesting year. A luncheon picnic, with Dr. Harrison B. Wilson, President of our Medical Society, as guest, will be our first meeting. Other programs for the year include "Flower Arrangements", "Book Reviews", "Travelogue on China" (in costume), "Talk on Allergy" by Mrs. A. F. Coca, and a "Hobby Night".

Our Medical Society this year has asked the Auxiliary to participate in and to arrange their annual banquet on November 12. We feel greatly honored and are busily working to make this dinner-dance a success.

Our chief philanthropy is aid to needy doctors' families. A card party in the Spring is planned to raise money for this purpose.

A letter of invitation to membership has already been sent by our Membership Chairman to each eligible person. Results have been gratifying.

We doctors' wives in Bergen County stand ready to work with the Medical Society in the Medical Preparedness Program they have outlined for us. The questionnaires are being distributed and will be returned, I feel sure, quickly and with gratifying response.

MRS. HOWARD M. MEYER, President,
Auxiliary to the Medical Society of
Bergen County.

BURLINGTON COUNTY

This year in Burlington County the Auxiliary to the Medical Society is resolved to follow out the suggestion of the Executive Board and make our program more valuable to us and to our community.

To assure ourselves of sufficient funds to pay the tuition and maintenance of the student nurse whom we send through training school (Burlington was the first county in New Jersey to do this), every member has been urged to guarantee a four-dollar table at a large card party to be held before Christmas. Helping a county girl in this way will continue to be one of our main projects this year.

The Burlington County Auxiliary started sending cookies regularly to the recreation center at Fort Dix last year. Doctors' wives from this county still are making, collecting and sending thousands of cookies to Fort Dix each week. And many members of the Auxiliary serve as hostesses at the Fort.

Besides the medical speakers at the Public Relations tea which we have each year, the doctors' wives are going to try to secure doctors as speakers for as many lay groups as possible. Four doctors will speak to us at our own monthly meetings.

In every way we want to help our country this year. Already our women are filling out the blanks of the Survey of Trained Personnel Available in the Women's Auxiliary to The Medical Society of New Jersey. If major disaster come to our own doors, we shall have placed ourselves in some helpful position. However, many members of the Burlington County Auxiliary have already been working steadily for the American Red Cross and for the British War Relief.

These, then, are the high points in the plan to make the 1941-1942 program of the Burlington County Auxiliary to the Medical Society meaningful to us and to our county.

MRS. E. H. WYMAN, President,
Auxiliary to the Medical Society
of Burlington County.

"FELLOWETTES"

The second meeting of "The Fellowettes" was held in Trenton on September 15. The President, Mrs. A. H. Lippincott, presided. Mrs. Lippincott explained that the Past-Presidents were organized as a social group; but that we were willing to aid in any project when

called upon by the Medical Society and the State Auxiliary. She added that we would notify the Medical Society that we were organized and offer our services.

After considerable discussion, the following recommendation was made to the Chairman

of the Revisions Committee of the Woman's Auxiliary to The Medical Society of New Jersey:

"The election of officers of the Woman's Auxiliary to The Medical Society of New Jersey shall take place at the Annual Meeting of the Auxiliary. The officers so elected shall take office on the following June 30."

This recommendation was thought wise to clarify the standing of the State President at the A. M. A. Convention.

The Fellowettes decided to buy a pin for the State President to wear during her year of service to the State Auxiliary, the pin to be the property of the State Auxiliary.

On October 13th at the Fall Board meeting such a pin had been purchased and was presented to our State President, Mrs. Oswald R. Carlander, as part of the program for the day. The presentation was made by Mrs. A. H. Lippincott, Program Chairman, first President of the State Auxiliary, and the President of the Fellowettes.

It was decided that the Fellowettes would meet once a year at a dinner during the Annual Convention of the Medical Society, the arrangements for the dinner to be made by the Junior Past-President. The task of the first dinner was thus allocated to Mrs. R. J. McDonald of Paterson. Mrs. Don Agard Epler is Secretary-Treasurer of the Fellowettes.

STATE BOARD MEETING

The first meeting of the Executive Board was held in Camden on October 13. Our President, Mrs. O. R. Carlander of Merchantville, presided. Attendance was 55. The meeting was open to all Auxiliary members. A delightful luncheon was served; this was in the capable hands of the Hospitality Committee of the Camden County Auxiliary, who have long shown themselves to be superior hostesses.

The business meeting of the morning had a pleasantly snappy and businesslike air. Interesting and inspirational reports were read by the chairmen of state committees, many of which contained good suggestions for county chairmen of similar committees. There was much discussion on the question of appointment by the National Auxiliary of an Executive Secretary to handle the correspondence of that group. Our members approved the appointment but disapproved of any further levy of dues to defray expenses of a secretary. The new Year-Book cover was chosen, a patriotic one of red, white and blue. It was decided to hold the January Executive Board meeting in Trenton and the March meeting in Newark as in past years.

Dr. William Dodd, Chairman of the Advisory Committee of the Auxiliary, spoke after luncheon. Dr. Dodd had no difficulty catching the immediate attention of the ladies for he started with many compliments to the Auxiliary. He likened the extensive outlines of our year's activities to a huge food market from which each county may make selections according to its tastes and needs. Counties with large memberships may order the whole menu and digest it easily; smaller organizations will have to order more sparingly. The menu contains "Medical Preparedness and National Defense", "Nutrition and National Defense",

"The American Way of the Practice of Medicine", "The Hospital and Your Community" and "The Medical Service Plan". Dr. Dodd praised the local project idea for individual counties, but hoped for uniformity of endeavor and effort for the general success of the national program.

Dr. Thomas K. Lewis outlined the rôle which The Medical Society of New Jersey is asking the Auxiliary to assume in the Civilian Defense Program. The Society is asking aid in two types of emergency—sabotage and invasion. Through questionnaires it will classify women volunteers into three groups: (1) trained nurses, (2) those with other special training, and (3) those without special training for work relating to the medical field.

Those in the first group will be asked to form operating room teams, to participate in delivery teams for obstetric cases and to serve as head nurses in emergency wards, in evacuation, clearance and base hospitals. For this group refresher courses are being planned.

The second group, in emergency, will be assigned to clerical forces in hospitals, or will be asked to serve as dietitians, technicians in laboratories, x-ray, electrocardiography, basal metabolism, physio-therapy and anaesthesia.

Untrained volunteers will be used as messengers for serving of food in emergency hospitals and as nursing assistants. This group will be asked to look after families of women actively engaged in hospitals. Special courses for nursing assistants will be established, probably through the American Red Cross.

"These services will not be required except in major emergencies in your own local areas," Dr. Lewis told the members. "It is assumed that the majority of doctors' wives are not available for remote service because of family

duties, and therefore we are not infringing on the activities of other agencies such as the Red Cross and nursing organizations."

The President of The Medical Society of New Jersey concluded by asking that the Auxiliary members familiarize themselves with "the American way of the practice of medicine". He urged that some phase of medical practice be scheduled for discussion at every meeting in order that the members might be factually prepared to defend and preserve it.

Reports of the county presidents were read and questionnaires for members were distributed for the presidents to take to their counties. Dr. Lewis urged prompt attention to this.

Mrs. Thomas K. Lewis was a guest at the luncheon and was introduced by Mrs. Carlander as were the Past Presidents, who were seated at the speaker's table.

The meeting was adjourned at three p. m.

MRS. ASHER YAGUDA, Chairman,
Press and Publicity.

Atlantic County

Reported by Mrs. Louis Feinstein, Press and Publicity Chairman

The first fall meeting of the *Woman's Auxiliary to the Atlantic County Medical Society* was held at the Traymore Hotel, October 10. The meeting was opened with our President, Mrs. Morton Major, presiding, who introduced Mrs. Mosiman, national President of the Woman's Auxiliary. Mrs. Mosiman gave a brief talk on the coming national convention to be held here in June, at which time Mrs. David B. Allman will act as chairman. She also told us that news of the convention and other articles of interest would be found in the Bulletin. She stressed the main project of interest, Health Defense, which includes nutrition, sanitation, etc.

We then had the pleasure of hearing Dr. Harry Subin, President of our County Medical Society. He extended the good wishes of the Society to the Auxiliary and assured us of whole-hearted support, coöperation, service and assistance. He predicted that we will be closer with the members of the Medical Society this year due to the nation-wide program of Civilian Defense. We must help protect the health of the nation, county and city. Another important suggestion was to publicize the buying of Defense bonds. A committee will be appointed by our President for the distribution of these bonds.

Further announcements were made during this meeting of the Sweepstakes Dance to be held on Saturday, December 6, 1941, with Mrs. Samuel Gorson as chairman, and the Reciprocity Tea to be held Friday, January 16, 1942.

Mrs. Ily Beir, Chairman of the Red Cross, would like volunteers to aid her in this drive, which will now be held in the new manner of house-to-house canvass instead of the usual stations.

Highlight of the meeting was the excellent and vivid book review given by Mr. Ben Barkan, professor of English at the Atlantic City High School, on "That None Should Die" by Frank B. Slaughter, M.D.

Attending this meeting were: Mrs. Lawrence Wilson, Mrs. Joseph Poland, Mrs. W. P. Chalfont, Mrs. Robert Bradley, Mrs. Allan Reick, Mrs. W. Stewart, Mrs. Carl Surran, Mrs. P. C. Joy, Mrs. Anthony Merendino, Mrs. R. Westney, Mrs. Charles Hyman, Mrs. Sidney Rosenblatt, Mrs. Bernard Crane, Mrs.

M. Mally, Mrs. Harry Subin, Mrs. Morton Major, Mrs. A. Grechmer, Mrs. Shreves, Mrs. Daniel Reynier, Mrs. James H. Mason, Mrs. D. B. Allman, Mrs. Samuel Gorson, Mrs. Samuel Salasin, Mrs. I. Beir, Mrs. S. Shuster, Mrs. Mishler, Mrs. Moriman and Mrs. Louis Feinstein.

Burlington County

Reported by Mrs. Luther M. Hartman, Publicity Chairman

The *Woman's Auxiliary to the Burlington County Medical Society* met at the Fireside Cottage, Mt. Holly, for a luncheon on October 6 to hear Dr. Harry L. Rogers of Riverton speak on "Allergy".

The Auxiliary discussed the Fort Dix Cookie project and made arrangements for a card party to raise funds for the Nurses' Scholarship.

Camden County

Reported by Mrs. James N. Barroway, Publicity Chairman

The regular meeting of the *Woman's Auxiliary to the Camden County Medical Society* was held on Tuesday afternoon, October 7, 1941, at the home of the President, Mrs. George B. German. There were forty members and guests present.

Routine reports were received from the officers and chairmen.

Mrs. William Braun announced the Annual Card Party to be given on March 2nd, 1942, at the Walt Whitman Hotel, Camden, N. J., with a Fashion Show by Oppenheim Collins of Philadelphia, Pa.

Mrs. Lester R. Wilson read four letters of appreciation from organizations to whom donations were made last spring.

Mrs. German announced that the fall meeting of the Executive Board of the Auxiliary to The Medical Society of New Jersey will be held on Monday, October 13, 1941, at the Walt Whitman Hotel. She urged all to attend.

Dr. Robert S. Gamon, newly appointed adviser to the Auxiliary, extended greetings from the County Medical Society.

Mrs. Henry R. Tatem, Program Chairman, presented the guest speaker, Dr. Thomas K. Lewis, President of the State Medical Society, who deliv-

ered a most stimulating talk on "Emergency Medical Service for Civilian Defense".

The Hospitality Committee, headed by Mrs. Robert S. Gamon, arranged for the tea that followed.

Hudson County

By Mrs. Abram Weiss, Press and Publicity
Chairman

The *Woman's Auxiliary to the Hudson County Medical Society* opened its season with a membership luncheon on Monday, October 6, at the Y. W. C. A. in Jersey City. Mrs. Andrew Ruoff, President, presided, and welcomed the members.

Miss Rosemary Oxford of the Home Economics Department of Public Service gave an interesting talk on the timely subject of "Nutrition and Defense".

Mrs. E. Curtis Plant, Chairman of the Red Cross Volunteer Service, described the courses open to women to assist in defense work, and asked the cooperation of all present.

Mrs. A. L. Krueger, Program Chairman, announced the plans for the year, which will include, among other interesting events, two tours, one through the new tuberculosis hospital in the Jersey City Medical Center, and another through the Margaret Hague Hospital.

Two new members, Mrs. Benjamin Markowitz of Jersey City and Mrs. Joseph Mastromonaco of Bayonne, were introduced, and each was presented with a red rose.

The tables were artistically decorated with pumpkins and autumn leaves.

Cards followed the luncheon, the top score winner receiving a box of handkerchiefs.

Mercer County

By Mrs. A. F. Moriconi, Press and Publicity
Chairman

Members of the *Woman's Auxiliary to the Mercer County Medical Society* held a luncheon meeting at the Trenton Country Club on September 29. This was in honor of the Past-Presidents of the society. Mrs. Oswald R. Carlander of Merchantville, President of the State Auxiliary, and Mrs. Lawrence L. Glover, of Haddonfield, were two of the prominent guests who attended. Mrs. Carlander spoke on "The Function of the Medical Auxiliary in Defense".

Mrs. George N. J. Sommer, President of the local Auxiliary, acted as hostess to the following honor guests: Mrs. William C. Ivins, Mrs. Frank G. Scammell, Mrs. John B. Sill, Mrs. D. Leo Haggerty, Mrs. James J. McGuire, Mrs. C. Chester Chianese, Mrs. Alton Fell, Mrs. O. R. Carlander and Mrs. L. L. Glover.

Fifty-one members attended.

Passaic County

Reported by Mrs. Joseph E. Mott, Press and
Publicity Chairman

The *Woman's Auxiliary to the Passaic County Medical Society* held the first meeting of the season at Highgate Hall, with Mrs. Alfred D. Meneve presiding, on October 20, in the form of a luncheon meeting. The new officers appointed since the annual meeting in May to fill the unexpired terms caused by the resignations of Mrs. Burt Bothyl as Treasurer and Mrs. Charles B. Russell as Second Vice-President were present and introduced. Mrs. James S. Gallo succeeds Mrs. Charles B. Russell and Mrs. Richard J. McDonald succeeds Mrs. Burt Bothyl.

The guest speaker was Dr. Sigurd W. Johnsen, whose topic "Economics of Medicine" was appreciatively received by the members.

Union County

Reported by Mrs. Rowland P. Blythe, Chairman,
Press and Publicity

With the State President, Mrs. O. R. Carlander of Merchantville, as the guest speaker, the *Woman's Auxiliary to the Union County Medical Society* opened its season with a luncheon meeting in honor of new members at the William Pitt Tavern in Chatham on Tuesday, October 14th. Mrs. Carlander was introduced by the County President, Mrs. George Knauer of Elizabeth, and spoke on "Medical Preparedness". She stated that doctors' wives who are nurses will be asked to take "refresher" courses. These are being given in twenty-five New Jersey hospitals to bring graduate nurses up-to-date on all modern nursing technique and equipment, so that they will be available to act in case of emergency and disaster in their own community.

The following were welcomed to membership: Mrs. Fletcher Gilpin of Cranford, Mrs. F. Glassner of Roselle, Mrs. Walter F. Phelan of Elizabeth and Mrs. Leonard Williams of Plainfield.

Warren County

Mrs. Elizabeth Curtis, Secretary

The *Woman's Auxiliary to the Warren County Medical Society* met October 23 at the Belvidere Hotel for a luncheon session and business meeting.

It was planned to schedule a series of card parties to secure funds for a room at the Warren Hospital.

Members were present from Washington, Belvidere and Phillipsburg.

The next meeting will be November 21.

Annual Red Cross Roll Call, November 11-November 30. Will you be counted in?

Letters to the Journal

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Letters commenting on material in the *Journal*, as well as suggestions for the welfare of the Society, may be directed to "The Editor", Medical Society of New Jersey, 143 East State Street, Trenton. The Publication Committee reserves the right to edit, reject or abbreviate any letters submitted.

Dear Editor:

Referring to the editorial³ on "Defense and Bureaucracy", may I point out that the matter is much broader than its medical aspect alone. If we are to have a bureaucratic government in this country, medicine will not be exempt; if there is a revival of personal liberty after the war, medicine will share in it.

In the meantime, if we are to be consistent in defense of individual rights, we must beware of setting up a medical bureaucracy of our own; the tendency is already manifest.

I am glad that you have revived the "Letters to The Journal" department, as it is a useful feature to a Journal like ours.

ELIAS J. MARSH, M.D.,
President-Elect,
Medical Society of
New Jersey.

Dear Doctor:

An osteopath has recently been sending physicians a pamphlet called "Fears—How to Banish Them". A critical review of this brochure is necessary, because it contains frequent unscientific half-truths, contradictions and misstatement of facts that may influence the unwary.

Modern psychotherapy is a complicated field. It contains many diverse forms of treatment, such as reëducation by insight, suggestion, hypnosis, psycho-analysis and occupational therapy. He does not mention any of these forms of treatment. He has some nebulous ideas that he calls mental, physical and spiritual treatment. But, the entire plan of his essay becomes clear when he mentions that manipulation of the "osteopathic lesions" is necessary. Obviously, our amiable

osteopathic colleague is trying to propagandize for osteopathy.

This brochure, in brief, has no scientific validity. It merely contains smatterings of antique psychology. It must be emphasized that amateurs in psychiatry are as dangerous as amateurs in surgery, no matter how gifted or sincere the amateur may be.

THEODORE ROTHMAN, M.D.

Dear Doctor:

Your publishing the American Academy of Pediatrics' recommendations for the improvement of school medical service is timely. The improvement of the health and nutrition of our children is the project for the year of the Child Health Committee of The Medical Society of New Jersey.

In the introduction it places the responsibility squarely upon organized medicine for raising standards. This means that our Society should use its influence to have doctors appointed to school positions because of their pediatric knowledge. Remember that the community and school authorities will come to the realization of this only if Medicine takes the lead.

The state school laws specifically state that the only treatment allowed is first aid. The school doctor can do only a screening examination with the facilities he has. This classifies but does not diagnose or treat. This has to be done by the private physician whose knowledge of children must also be of a high standard.

I was also interested in the article on Simultaneous Immunization¹ by Simon and Craster. But it seems to me desirable to develop some method which will reduce the number of hypodermics

which have to be given to children and infants. Each immunization must be perfected individually. Their acceptance by the public depends largely on their freedom from reactions. The latter in diphtheria immunization has been reduced to a minimum and it is almost a hundred per cent perfect. This cannot be said of immunization to whooping cough.

Whooping cough is most dangerous in the first two years of life. Therefore, immunization has to be done early. Six months of age seems to be the most desirable time to protect the infant against whooping cough. But, as the article states, nine months is the optimum time for diphtheria immunization. The public knows these facts and is not willing to postpone the one or hasten the other.

It would be of interest to do a series at seven and a half months and see if the results are as good. If, as suggested in the paper, there is an added potency to the two solutions by combining them, this might solve the problem.

Dr. Wolf's article² is an exceptionally good outline of the history and treatment of rickets. The fact that some preparations of vitamin D are toxic does not seem to be generally known.

Even though similar work has been done by others, it would be more convincing if there had been more cases in the series. This is particularly true as the treatment is a decided departure from that which has been the accepted therapy for years.

Further observations at one and two years will be of interest. These observations should be both x-ray and clinical.

CHESTER R. BROWN, M.D.,
Chairman, Child Health
Advisory Committee.

3. See page 434 of Sept. *Journal*.

1. See page 461 of Sept. *Journal*.

2. See page 436 of Sept. *Journal*.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XIV

November, 1941

No. 11

MORTALITY from tuberculosis has been quartered in forty years. This fact, however, reveals no accurate information regarding prevailing infection and morbidity rates. That they are less is too logical a deduction to be doubted, but their decline relative to that in mortality has been a matter of conjecture. The following report on autopsy findings throws valuable light on this question, especially since accurate studies extending over the past half century furnish the needed controls for comparison.

PREVAILING TUBERCULOSIS INFECTION RATE

In 1900 Naegeli published a careful report of 508 autopsies. Of the adults over 18 years of age 93% showed healed, inactive or active tuberculous lesions in the lungs. Only 17% of those under 18 yielded positive findings. Other investigators substantiated these findings and in the early years of this century the belief was prevalent that all adults had at some time suffered an invasion by the tubercle bacillus.

Opie as late as 1917 found positive evidence of infection in all of 50 autopsies on adults and in nearly 24% of a group of 93 children, the latter showing a far higher figure in the adolescent years. It was these findings that led Opie to remark, "Almost all human beings are spontaneously 'vaccinated' with tuberculosis before they reach adult life."

In 1922 Wason reported positive findings in 82% of his autopsies and in 1925 Lambert and de Castro Filho reported a rate of 72.8% in a large series from Brazil. As late as 1927 Todd still found evidence of tuberculous infection in 69% of autopsies done in Edinburgh on patients who had died of some cause other than tuberculosis. Such evidence indicates rather clearly that decline in infection rate has not kept pace with mortality from this disease.

The present study was carried on at the Washington County Hospital in Hagerstown from September, 1938, to August, 1940, all autopsies being performed by the same pathologist. There were 176 autopsies during this period which represented 45% of the deaths which occurred. Eleven of these were rejected because they were not complete postmortems, leaving 165 which are included

in this report. Cases of active tuberculosis are not admitted to the hospital. The population of Washington County is semi-rural and most of the patients were long residents, from all classes of society and of the white race (only four Negro adults in the group).

Thirty-two of the 165 necropsies were done on children and 133 on adults. For the whole group positive findings were recorded in 65 or 39.4%, which is just half of Naegeli's findings, 79.9%, when he included all ages.

Considering only the adult group of 133 cases, the positive evidence of infection yielded 47.4%, again strikingly near one-half the number of adults found to be infected by the earlier researches of Naegeli, Burkhardt, Opie and others. In this series there were five cases where infection was suspected but could not be proved pathologically. If these are included the percentage would stand at approximately fifty.

This finding of almost 50% of positive tuberculosis among an unselected group of a semi-rural population indicates that the frequency of tuberculosis is still sufficient to be alarming. If one assumes this experience as typical of the country as a whole, which seems reasonable, we must still face the fact that at least half of all adults have suffered invasions by the tubercle bacillus active enough to leave discoverable scars. This is disconcerting in face of the far greater fall in the death rate from the disease.

At the same time there is some compensation in the discovery revealed by this study that only one-half as many people who have suffered tuberculous infection actually die of the disease as was

the case forty years ago. The infection rate has been reduced to 50%, the mortality to 25% of that in 1900. A number of factors have probably contributed to this gratifying preponderance in the decline of the death rate. Better sanatorium care and the management of cases has undoubtedly made a large contribution. The fact that lessening of the infection rate has apparently shown acceleration in the past 15 or 20 years brings comfort both to those engaged in the preventive and therapeutic aspects of tuberculosis control. A 50% reduction in the reservoir of spreaders must certainly mean that fewer contact cases are today submitted to massive and repeated doses of infected material. The contribution of compression therapy and surgery to this result can but be inferred. Those who advocate freer use of these measures certainly would seem to have little for which to apologize in the evidence presented by this study.

However, there are other factors in the picture which perhaps deserve first mention. Isolation is the time-honored scheme for the control of epidemic, infectious disease. It is a significant coincidence that during the period when tuberculosis mortality was reduced to one-quarter its 1900 level and infection rate cut by 50%, the sanatorium beds in this country increased from about 6,000 to 100,000. It would be idle not to recognize this prophylactic procedure as an outstanding influence in lessening opportunity for infection among the general public.

The result of this procedure would have been far more striking had it been possible to arouse the medical profession to its responsibility in finding the early case and effecting its immediate isolation. Unfortunately, this is one of the weaker links in our control program. From three-quarters to four-fifths of all cases admitted to sanatoria are still found to be in the advanced stages of the disease, already probable spreaders of the infection to others. More professional education, both undergraduate and postgraduate, is still needed to impress upon physicians how truly further progress in tuberculosis control rests in their hands.

Popular health education and school hygiene have also played their parts in reducing opportunities for infection. Beginning with teaching the infectivity of sputum, the transference of disease through common utensils, uncleanness in restaurants, the menace of infected food handlers, instruction has proceeded to the point where even

an open case is of relatively little danger to his fellows if both he and they will exercise the prophylactic measures now recognized as largely effective.

Finally, better housing, elimination of industrial hazards, more applied knowledge of the laws of nutrition, and a growing consciousness of the significance of personal and community hygiene, all have played their part in reducing the transmission of tuberculous infection from case to contacts.

A highly significant factor in this study is the observation that reduction of infection as shown at autopsy has been at least as rapid among infants and children as among adults. These younger members of society can make no personal contribution to their own protection. They must rely on that of others, nurses, teachers, parents and relatives. Cutting their infection rate in two as well as that of their elders is clear proof that a better informed public is making an increasingly effective fight against spread of this disease.

Frost in discussing the eradication of tuberculosis wrote as follows: "Tuberculosis also differs from the other directly transmitted respiratory tract infections in that its mortality has declined consistently for the last fifty years or more and continues to decline in every part of this country for which adequate statistics are available. It is not directly established by comparable statistical evidence that there has been a proportionate decrease in the prevalence of infective cases of the disease, taking into consideration not only the number of cases but duration of the open stage. However, there appears to be no good reason to doubt that the prevalence of open lesions effective in spreading the tubercle bacillus has diminished progressively, and continues to diminish in each considerable period of time."

However, it must not be overlooked that, according to present autopsy records, the reservoir of adults infected with tuberculosis at one time or another in their lives still amounts to half of the population. Therefore, tuberculosis can still flare up again whenever external conditions turn to the worse for the bulk of the people. Without such a reverse there exists the hope that further efforts in the campaign against tuberculosis will some day lead to a complete eradication of the white plague.

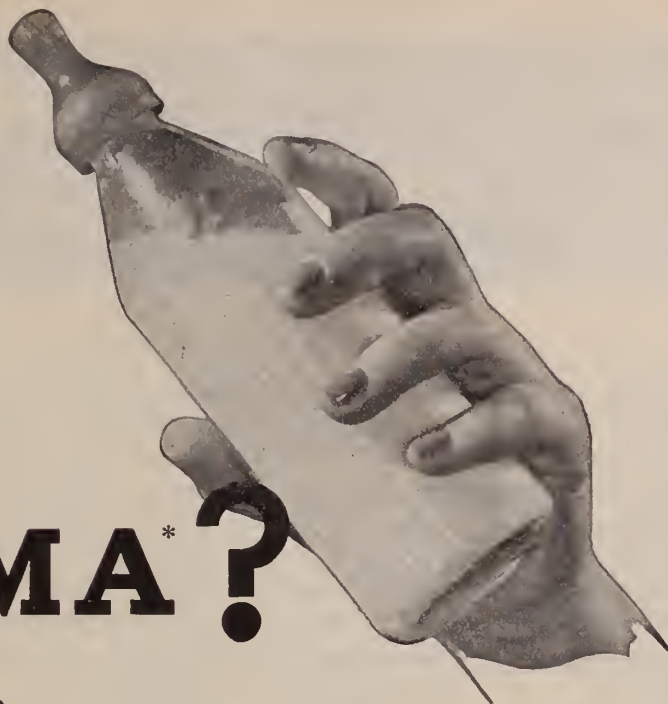
Frequency of Tuberculous Lesions at Autopsy by Kurt E. Lande and Georg Wolff, *Amer. Rev. of Tuber.*, Vol. XLIV, No. 2, Aug. 1941.

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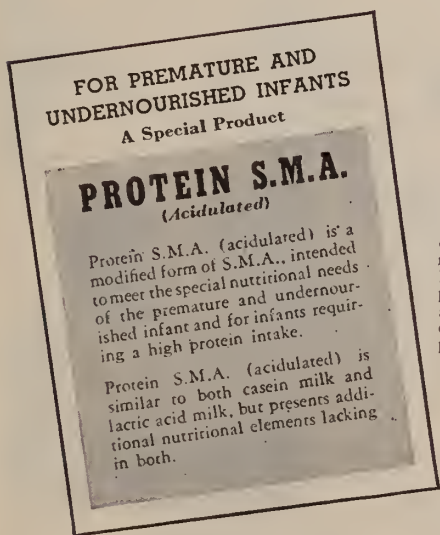
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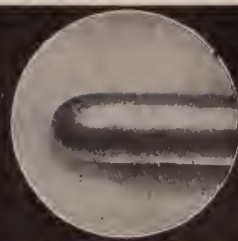
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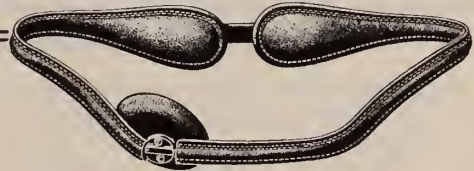
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*J.A.M.A., Vol. 93, No. 15, p. 1110, Oct. 12, 1929

Bruckner, Die Biochemie des Tabaks, 1936

**The Military Surgeon, Vol. 89, No. 1, p. 7, July, 1941



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1936. Mass. Agr. Expt. Sta. Bull. No. 338.

1937. Chemistry of Food and Nutrition, Fifth Edition, H. C. Sherman, MacMillan, N. Y.

1938. Nutrition Abstracts and Reviews 8, 281.

1939. Food and Life Yearbook of Agriculture, U. S. Dept. Agr., U. S. Government Printing Office, Washington, D. C.



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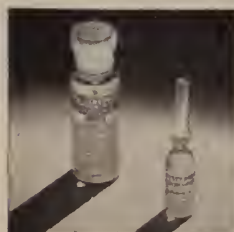
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Lithium chlorid	21.07	64.49	46.43
Potass. chlorid	361.91	789.54	714.86
Sodium chlorid	2,010.48	8,594.84	4,233.14
Potass. bromid	9.23	160.00	13.90
Potass. iodid	1.10	4.80	1.36
Sodium sulphate	None	None	None
Sod. metaborate	Trace	None	Trace
Sodium nitrate	Trace	Trace	Trace
Sodium nitrite	Trace	Trace	Trace
Sodium bicarb.	2,213.78	424.71	1,331.15
Calcium bicarb.	1,829.14	3,380.84	2,519.74
Barium bicarb.	16.67	25.65	25.00
Strontium bicarb.	Trace	Trace	Trace
Ferrous bicarb.	9.94	40.07	5.86
Magnes. bicarb.	753.89	2,244.88	1,186.57
Alumina	7.14	4.98	6.37
Silica	19.40	14.40	12.80
Total	7,284.00	15,808.30	10,130.48

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1 Elvehjem, C. A. — Nutritional Requirements of Man — Ind. & Eng. Chem., June 1941.

2 McCollum, E. V. — The Newer Knowledge of Nutrition — 5th Ed., 1939, p. 392.

3 Mc Lester, J. S. — Nutrition and Diet in Health & Disease — 3rd Ed., 1939, p. 91.

4 McCollum, E. V. — The Newer Knowledge of Nutrition — 5th Ed., 1939, p. 320.

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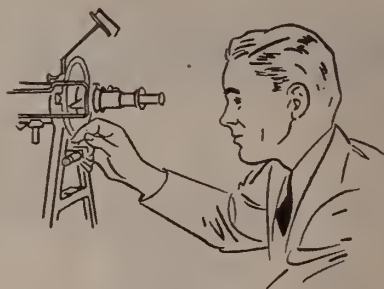
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THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

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COMMITTEE ON PUBLICATION



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DECEMBER, 1941

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HEALTH INSURANCE AND THE INCOME CEILING A MESSAGE FROM THE PRESIDENT

In 1933, publication of the Wilbur Committee Report shocked the medical profession into a realization that something was radically wrong with the economic aspects of medical care. In that year, during the administration of Dr. Quigley, The Medical Society of New Jersey organized a Medical Practice Committee whose studies subsequently revealed the fact that modern scientific techniques had so increased the cost of the care of illness that changes were needed in methods of distributing medical care. Below the financially highest group, three economic segments of the public had to be assisted. These were the "middle class", workers in the low-wage group and the indigent.

The "middle class" comprises the bulk of our population. These families can meet the cost of ordinary medical care, but plunge beyond their financial depth when faced with catastrophic illness. Surely it is evidence of an unsound economic state when members of this group are forced either to accept medical char-

ity or to burden themselves with crushing debt to meet the cost of catastrophic illness. It is in this group that there have been planted seeds of doubt as to the soundness of existing methods of medical practice; and out of this group has come much of the demand for some sort of state control of medical practice.

Let it be noted that the "middle class" is made up of many kinds of people, stemming from different roots, adhering to diverse standards of living. It includes white-collar workers who often receive lower wages than the laborer while being required to "dress up" to a white-collar level and maintain a generally high living standard. It includes, for example, the educator whose salary is scarcely that of a skilled mechanic but who is expected to adhere to "upper-class" living standards. It includes persons receiving excellent wages during seasonal employment but with scant income during lay-off periods. For this group, calculation of annual income is often misleading. It includes many persons now profitably em-

ployed who are still paying heavy debts accumulated during the depression. And rising living costs and possible inflation curtail the paying ability of those with fixed incomes.

It becomes apparent, then, that it is impossible to fix a satisfactory living wage. The meaning of an income level varies too much, and its evaluation is subject to the law of relativity.

For these reasons the application of an income ceiling in Plan II of the Medical Service Administration is impractical and unjust, and would indeed defeat the purpose for which the Administration has been set up. Catastrophic illness is precisely the kind usually covered by Plan II, and precisely the kind which spells financial calamity to most families in this "middle bracket". Removal of the income ceiling has therefore been proposed in Plan II. To be sure, unfair advantage may be taken of this by a few; but if we in the medical profession maintain our long-standing and respected reputation for having, in abundance, the milk of human kindness, it behooves us—for the sake of that heritage which we have received, as well as for the sake of humanity—to make this effort to aid the great middle class bear its medical burden. This we can do by the whole-hearted support of the Medical Service Administration.

What of the other two economic classes—the low-wage earner and the indigent?

The latter were provided for, during the depression, by the Emergency Relief Administration. And in spite of the return of a more normal economic state, there is still need for community support of the doctor's effort to give care to this group. The Medical Service Administration is now negotiating with state and municipal authorities on a project to take over this service under Plan III.

For the low-wage earner, medical care will eventually be provided on an insurance basis under Plan I. Since services here must be within the economic capacity of the low-wage earner, fees to physicians will probably be at a somewhat reduced rate. Obviously, therefore, such insurance must be limited to those of low income, and a definite income ceiling must be established for eligibility to the benefits of Plan I.

Your Medical Service Administration is thus prepared to meet these problems on every front. With the full support of the doctors of New Jersey, we can preserve individual liberty, free choice of physician, and medical leadership. This project is unregimented in method, voluntary in support, democratic in procedure. And these, we believe, are the keystones of the American Way.

THOMAS K. LEWIS, M.D.

President

The Medical Society of
New Jersey.

BEDSIDE CONFERENCES

Many of us have been startled to find that the patient who, we thought, was asleep, unconscious or uncomprehending, has suddenly sprung into vivid anxiety in the course of a bedside conference. When the chief with his train of associates, adjuncts, assistants, residents, and interns, cluster around a bedside, the cause of medical education may be advanced. But the patient may be emotionally traumatized.

Consider the sequence of events. The intern reads the history and the patient listens with open ears. Such items as alcohol habit, suicidal attempts, exposure to venereal disease, death of relatives from carcinoma or diabetes—all evoke his anxiety. For instance, the patient may not have thought one way or another about the possibly hereditary aspect of cancer. But if the intern takes the trouble to say that the father and paternal

grandmother died of carcinoma, the patient is then justified in thinking that this ancient history must have some meaning.

It would seem wise to prepare a patient by having the nurse or intern tell him in advance that there will be a conference at his bedside. Discretion would suggest that the patient be told that his case is interesting rather than that it is difficult. All people enjoy having "interesting" disorders, none enjoy having difficult ones. The shade of meaning in "interesting" as contrasted with "difficult" may be enough to tip the scales towards or away from anxiety. For example, if a patient is told that so many doctors are at the bedside because his case is difficult, he may wonder at the competence of his physicians. If he is told that the medical gallery surrounds him because he has a "most interesting" case, his emotion is likely to be pride rather than fright.

Of course it is wise for the doctor to use even more technical language than he ordinarily employs. If the chief were to ask the intern: "How can you tell that this lesion is due to anthrax rather than syphilis, leprosy or tuberculosis?" the patient will be sure to hear only the last three words and to assume that he is the unfortunate victim of all three scourges. This imposes upon the physician the need of using an intentionally obscure terminology. On the other hand it is to be remembered that patients are fairly well educated today and that you cannot fool the average layman by calling his cancer "Ca", still less by calling it a "malignancy". Any reasonably bright layman can translate "Ca", and the word "malignancy" itself carries fearsome implications. As yet the public has not caught up with the word "neoplasm", the only safe euphemism under the circumstances. Naturally the word "tumor" must be avoided since even a benign growth, if called a tumor, will convey to the patient the picture of cancer.

Venereal diseases are no longer disguised by such words as Wassermann,

G. C. or lues. The patient has become familiar with the first two terms and is now learning the third. Probably the adjective "luetetic" is still meaningless to most laymen, hence the need of elaborate circumlocutions like: "Does this mass appear to be luetetic or neoplastic?"

Tuberculosis is, of course, not concealed by calling it "T. B." though it probably remains obscure under the name "phthisis", "acid-fast" or "Koch's bacillus".

How to talk about the neurotic without stigmatizing him is another lexicographic problem. To speak of the condition as "functional" is still enough to shield the patient's self-respect. To call it "HYS" is to give the show away. To brand it "neurotic" or "psychoneurotic" is to give the patient, in his own mind, the label of a malingerer or hypochondriac.

A few practical suggestions would seem to be: great care in choosing the vocabulary; careful reading of the history on the part of the intern to avoid or euphemize the distasteful fragments of the history; the constant presence of a nurse at the bedside; and the frequent use of the patient's name.

The psychologic effect of the latter device is not sufficiently realized. For example, if the patient is constantly referred to in the third person as "he" or "the patient", and in the second person as "you", there will appear to be something almost too objective about the discussion. On the other hand, if the chief asks his associate: "What do you think we can do to make Mrs. Pappandria more comfortable?" or if he turns to the patient now and then and says: "Tell me, Mrs. Kozimar, is this pain much worse at night?" the examination is invested with an aura of pleasant intimacy rather than one of scientific frigidity.

Careless talk around the bedside can do much harm; and "never to do harm" is surely the Number One principle of medical practice.

THE MARGINS OF MEDICINE

Of the various encroachments on private practice, the most spectacular and most widely discussed is the increasing extent to which governmental agencies, corporations and insurance units are rendering diagnostic and therapeutic service. Less dramatic, but quite as serious and much more preventable is the erosion of the marginal disciplines into the medical field. By "marginal disciplines" we mean the quasi-medical practices which haunt the fringe of the profession, such as chiropody, optometry and the like.

The nibblers at the periphery of medicine fall into two groups: (1) Those that are all right in their place, and (2) Those that have no place. Suppression of their practice requires, in essence, a wider education of the public. To this end, several committees of The Medical Society of New Jersey, and two or three committees of the county medical societies, as well as one of the A. M. A. bureaus are devoting their efforts. How much can the individual physician do in this field? If a doctor, for instance, were to broadcast to his friends the opinion that a certain cult is hokum, he probably would be told that he was prejudiced, and that the world once laughed at Christopher Columbus too.

With the first evil, however, the problem is different. Where we admit that a certain practice is all right in its place, we cannot be charged with the sin of absolute dogmatism. It then becomes a problem of defining the "place" rather than denying the basis of the discipline. Yet we have not been very successful in stopping the encroachments of the marginal practices. One reason is that each doctor views with little concern the quasi-professional layman in fields other than his own. Ophthalmologists may be disturbed at the expanding activities of optometrists, but the general surgeon shrugs his shoulders, and says it isn't his problem. Recently, at a committee meeting, a member suggested something

be done about educating the public as to the difference between commercial x-ray laboratories and medically operated roentgenologic offices. The other committeemen, however, asked why a society of four thousand members should be disturbed about an encroachment into the field of a few dozen x-ray men.

This spirit impairs your Public Relations Committee's effort to do anything about the problem. Every physician must realize that keeping the unqualified amateurs out of tampering with medicine is his problem.

The marginal disciplines which may be all right in their respective places, but which sometimes overflow their banks, include: (1) Optometrists (2) Masseurs (3) Commercial Laboratories of all sorts (4) Counter-prescribing druggists (5) Midwives (6) Amateur psychologists who offer psychiatric advice to neurotics (7) Patent medicine purveyors who mount the lecture platform (8) Over-enthusiastic first-aiders who gallop to the scene of an accident prepared to set fractures and suture wounds (9) Operators of private gymnasias who offer, for a consideration, to put on weight or take it off, or who hold themselves out as able to build muscles or self-confidence with equal ease and money-back certainty (10) Chiropodists who treat club-foot and dermatoses, and (11) the lay administrator of unsupervised high colonic irrigations.

Against these over-zealous practitioners, the individual physician can take action. First, their activities can be reported to the State Board of Medical Examiners, so that to the extent that they represent unauthorized medical practice, they can be investigated and curbed. Second, the physician should realize that whether or not it is his own ox which is gored, the problem is one which merits his attention. Third, the doctor should be careful of his word choice in making recommendations to his patients and lay

friends. For instance, the patient should be urged to see an "eye physician" and not an optometrist. Conversely, on first examining a patient who wears eyeglasses, the doctor might ask: "Were these glasses prescribed by an eye physician. . . or just by an optometrist?" The patient may be bewildered a moment, but the educational idea will sink in. A similar campaign of quiet education can be conducted on an individual basis in regard to these other marginal disciplines, notably the commercial laboratories, counter-prescribers and patent medicine salesmen. Most epileptics, for example, are being treated by medicines bought through the mail. To say angrily to such a patient that his medicine is an ineffective nostrum is to make him suspicious of the doctor's good faith. But a few questions, as to whether the mail order advertiser ever examined the patient, and

a casual shrug of the shoulders are more likely to start the patient himself wondering about the advisability of treatment by post. In addition to this essentially individual kind of attack, the committees of the component county societies can exercise pressure in the right direction by several methods. One would be investigation and reference for prosecution. Or, in our public addresses to service clubs, P.-T.A.'s, and other lay groups, we could stress this point. Certainly, we as a profession, are sufficiently important in numbers, prestige and influence to exercise enough pressure to keep the marginal groups within the limits of their own capabilities. That much united action against a disorganizing outside influence can be expected of any organized occupational group.

PUBLIC RELATIONS COMMITTEE,
The Medical Society of New Jersey.

DEMAND AND SUPPLY OF PHYSICIANS

The medical schools have produced an adequate supply of graduates in medicine. At one time these men all entered private practice. To do otherwise was likely to be regarded as irregular or unethical; but evolution comes out of changes and today the medical graduate has a choice of specialized fields in which he can engage ethically, profitably, and with professional as well as personal satisfactions. Preparation for these special fields is not necessarily confined to medical postgraduate schools. In some of these one must "learn by doing" under the guidance of pioneers who have established and developed the early special services—in industrial health, in public health administration and supervision, in hospital and sanatorium administration, in medical so-

ciety administration, in school health supervision, in investigating and approving grants given to qualify men for specific health needs by Foundations which employ medically trained men.

Health is now a large and complex concept, and has many specialized fields of its own. To the younger medical graduates of today there are increasing opportunities for men of vision, initiative, and energy who will recognize and accept these new opportunities and fit themselves to succeed in these new fields rather than to join the already overcrowded field of general medical practice. Service must be adapted to human and social needs as they arise.

L. A. W.

ORIGINAL ARTICLES

THE TECHNICAL APPROACH TO THE SURGICAL ABDOMEN *

By ROBERT S. GAMON, M.D., Camden, N. J.

In approaching a case of possible acute surgical abdomen, certain basic diagnostic procedures should be followed. True, some "inner hunch" or premonition may lead to the diagnosis, but this is not a dependable procedure and is usually an excuse for incomplete study of the case.

The essential difference between success or failure in the treatment of the acute surgical abdomen depends upon the prompt attainment of an early and conclusive diagnosis. A case seen shortly after the onset, which cannot be clearly and definitely stated to be a surgical abdomen, should be seen again within a few hours, without sedatives having been given in the interim. It is usually best to state a time at which the second examination will be made, preferably within four to six hours after the initial examination. This "re-check" of the suspected surgical abdomen may account, in part, for the fact that the largest percentage of our hospital admissions of acute surgical emergencies of this type are between 10 p. m. and 2 a. m. The patient had been seen for the second time by his physician on his evening rounds.

HISTORY

Despite the frequent apparent urgency of the case it is well to begin in a routine manner and secure a complete history, both of past and present illnesses. From this, we gain important facts as to the previous health of the patient. A history of chronic indigestion, relieved by eating or by the familiar sodium bicarbonate, suggests perforated ulcer. The history of pain, which is the one predominant symptom in the surgical abdomen, should be elucidated: the onset of the pain, its character, whether constant and severe, or whether of the colicky type. Whether the pain at the onset caused shock and collapse, its location and the region to which it is referred, all are most valuable

diagnostic aids. It has been said that abdominal pain, which persists for six hours, in patients previously well, is caused by conditions needing surgical intervention. This is a good general rule, but many conditions in the acute abdomen should not be permitted to continue in pain during this period of time without a diagnosis having been established and surgical intervention accomplished. The history of vomiting, especially its time relationship to the onset of pain, or the absence of pain, is of great significance. The manner of vomiting, whether of the continuous or recurrent or of the projectile type, should be recorded. The so-called "fecal" type of vomiting is rarely seen early in the acute abdomen but is extremely significant when appearing within the first few hours. This suggests a complete low small bowel obstruction. The history of persistent emesis, excluding generalized peritonitis, points to intestinal obstruction.

AGE

In the past few years there has been an increasing consciousness on the part of the profession as to the surgical abdomen in infants and young children. In the newborn we are confronted with persistent vomiting immediately after birth. In the absence of cranial injury this points to congenital obstructive abnormalities in the gut tract. Some of these can be remedied by immediate surgery. It depends on early recognition of the condition as a surgical problem. Aside from the congenital lesions of the newborn, the most common surgical abdomen, up to the age of three, is intussusception.

When the patient is past the fourth decade we see an increasing number of malignant obstructions. After eliminating strangulated hernia, this is the next most common cause of obstruction. Many go to the point of partial or even complete obstruction before the patient is aware of any abnormality. This is particu-

* Read at the Annual Meeting of The Medical Society of New Jersey, May 21, 1941.

larly true in lesions of the descending colon and recto-sigmoid. Here a careful history should bring out the gradual increase in constipation, which may alternate with diarrhea, and the increased frequency of episodes of gaseous distension of the entire abdomen.

PHYSICAL FINDINGS

The most important step in determining the presence or absence of a surgical abdomen is the physical examination.

The general appearance, facial expression and position of the patient in bed will often give a definite index as to the intensity of his symptoms. The sufferer from a perforated hollow viscus will remain in a fixed position, whereas the patient with renal or gall stone colic will be difficult to restrain during the examination. The blanched, shocked appearance of the recently ruptured ectopic pregnancy leads to the confirming bi-manual pelvic examination and an established diagnosis. The flaring nares, rapid respiratory movements, or the respiratory "grunt" in children, call attention to the probability of chest infection with referred pain in the abdomen. Also by a general inspection one may see a protruding hernia, peristaltic movements, the scars of a prior operation, possibly omitted in the history taking, as well as any prominence or inequality in the normal contour of the abdomen. Palpation of the abdomen should be done carefully and gently with the thighs flexed. It is well to have the patient point out the region where the pain began and its present location. The hernial orifices should be felt routinely, as a small femoral or umbilical hernia is frequently overlooked. Then beginning at the point on the abdomen most distant from the site of pain, a routine palpation is conducted. The presence of muscular rigidity is easily recognized and whether it is voluntary or involuntary can be ascertained by distracting the patient's attention from the abdomen during the act of repeating the palpation. In the early stages of inflammatory conditions of the abdomen, with the exception of perforation, there are varying stages of tenderness preceding involuntary rigidity. The involuntary muscle spasm is a defense mechanism to protect the underlying

inflamed viscus. When the peritoneum becomes involved the muscular rigidity remains constant above the area of inflammatory reaction. It is not necessary to await the appearance of rigidity to establish the diagnosis of surgical abdomen. The early and persistent boardlike rigidity is a result of the extensive peritoneal irritation of the spilled material and makes an immediate diagnosis of surgical abdomen possible. Bi-manual palpation of the liver may permit one to feel the fundus of the gall-bladder as it comes out from under the liver margin. However, in early inflammatory lesion of this organ there is only local tenderness and no rigidity. The presence of a mass in the abdomen above the pelvis is found infrequently in the acute or potentially acute abdomen. Intussusception in young children, ovarian cyst with long pedicle having become twisted, and malignancy in the colon can at times be palpated. Bi-manual palpation of the loins will bring out ptotic kidney or the painful kidney of pyelitis or pyonephrosis which often causes referred pain to the lower abdominal quadrants simulating intraabdominal disease. Thus it is by the careful and thorough manual examination of the abdomen that one is best able to localize the presence of acute lesions in the peritoneal cavity.

Auscultation will establish the degree and character of peristaltic movements. There is little change in the normal peristaltic waves in the early inflammatory process. However, the characteristic high-pitched tinkling peristaltic rushes, accompanied by colicky type pain is suggestive of small bowel obstruction. This may be heard before complete obstruction. It is not necessary to have distension, visible peristalsis and persistent vomiting of fecal type to establish the diagnosis of intestinal obstruction. Too often serious or irreparable damage is done if we await these late signs and symptoms.

Percussion of the abdomen is helpful in suspected cases of ruptured ulcer. The free air under the diaphragm obliterates the normal area of liver dullness and can best be noted by percussion over the mid-axillary line just above the costal border. The presence of free fluid in the abdomen as a result of intraabdominal hemorrhage can be recognized by percussion

of the flanks and checked as percussion note changes, on shifting the patient's position from side to side.

No examination of the suspected surgical abdomen is complete without rectal examination. It is only by this means, particularly in the male and in children of both sexes, that the pelvic appendix can be recognized. This is also the means of palpating rectal malignancy, most commonly found at the recto-sigmoid junction. Rankin states that over 75 per cent of rectal malignancy can be recognized by this simple means. Many of these cases will first present themselves as a result of partial or complete bowel obstruction, the symptoms being abdominal in character. Bi-manual pelvic examination in the adult female will usually establish the diagnosis of pelvic disease which may have confused the abdominal diagnosis.

It is well to make a brief neurologic check, as to the pupillary reaction, patellar reflexes and Kernig sign. Occasionally early meningeal symptoms with vomiting and secondary pain in the abdomen will be suspected to be a surgical condition. Neurologic examination will eliminate *tabes dorsalis*, presenting the picture of gastric crisis. All of the above parts of the examination may be done in the home, where the blood count and urinalysis may be taken.

LABORATORY FINDINGS

The blood cell count must be interpreted in conjunction with the clinical findings of the case. The white cell count in early inflammatory lesions of the abdomen is often only slightly above normal. In obstructive lesions there is rarely any change in the white cell count until secondary inflammatory reaction develops. Many acute appendices will be missed or delayed if the burden of the decision is placed upon the patient's blood picture showing a leukocytosis. The abdominal signs are of much greater significance. The additional proof of a leukocytosis in proportion to the temperature and increased pulse rate gives added assurance that the diagnosis is one of an inflammatory condition.

A routine urinalysis, with a catheterized spe-

cimen in female patients will be of considerable assistance in differentiating cases showing signs of renal colic or kidney infection.

ADDITIONAL AIDS

Additional diagnostic aids are available for the still questionable cases, provided the patient is hospitalized. These are needed in only a small proportion of cases.

Flat plate x-rays of the standing patient will often demonstrate free air under the diaphragm in suspected perforation of a hollow viscus. Its presence would definitely establish the diagnosis and it is particularly useful in those cases of perforated ulcer which do not present clear abdominal signs. Not all perforated ulcers give the classical picture of abdominal board-like rigidity. Using the same simple technique, cases of suspected intestinal obstruction will show fluid levels in the small bowel and also will demonstrate whether the obstruction is in the large or small bowel. It is also possible to localize the site of the obstruction with a fair degree of accuracy in both the small or large intestine.

Recording of temperature, pulse and respiration is routine. The duration of the disease exerts the greatest change in pulse rate and temperature. In the inflammatory group, the pulse rapidity is noted before any temperature change. In obstructive lesions there is usually little change in pulse or temperature until dehydration or secondary inflammatory changes occur.

SUMMARY

The approach to the suspected surgical abdomen should be an intelligent, methodical procedure. A co-relation of the history, age of the patient, physical findings and necessary laboratory studies should establish a fair working diagnosis in the majority of cases. Omission of any of the essential procedures may lead to mistaken diagnosis and a needless operation. It seems well to recheck the doubtful cases within four to six hours, during which time the symptoms may crystalize and clarify a difficult diagnostic problem into a simple one.

SULFAGUANIDIN: ABSORPTION, EXCRETION AND THERAPY

By C. ABBOTT BELING, M.D., Med.Sc.D., Newark, N. J.

and

ARTHUR R. ABEL, M.D., East Orange, N. J.

During 1940, Marshall and his associates¹ prepared a sulfanilamid derivative called sulfanilyl-guanidin. Their work embodied discussions of structure, chemical and physical properties, pharmacology and experimental therapy. They stated that sulfaguanidin was more soluble in aqueous media than other sulfanilamid derivatives in therapeutic use, that it seemed to be poorly absorbed from the gastro-intestinal tract so that high concentrations were observed in the stools, and that it had marked effect against streptococci, pneumococci and the colon group of organisms. They further suggested that the drug might have possibilities in treating infections of the colon. A subsequent report² by the same writers and one by Lyon³ indicated the value of sulfaguanidin in bacillary dysentery.

PRESENT STUDY

This study was designed to determine the absorption and excretion of single and multiple doses of sulfaguanidin,* the various concentrations of the free and conjugated forms of the drug in the blood, urine and stools, their correlation with each other, and the effect of these concentrations upon the flora of the large intestine.

The concentrations of free and acetylated sulfaguanidin in the blood, urine and stools were determined after the method of Bratton and Marshall,⁴ using trichloroacetic acid as a precipitant and N-(1-naphthyl)-ethylene diamine dihydrochlorid as the coupling agent. The stool specimens were handled according to the method described by Marshall and asso-

ciates.² This proved simpler and more reliable than refluxing the stools with acetone, which created odors that were so penetrating that the laboratory was unfit for other use at the time. When the concentration of sulfaguanidin was great in the stools or urine, dilutions of 1 to 200 were made to obtain accurate readings. If the developed color was too strong, difficulty was encountered in matching with the standard, and the free and total readings tended to approximate each other closely.

SINGLE DOSES

Seven apparently normal persons were given a single 3-gram dose of sulfaguanidin at 8 a. m. Venous blood was withdrawn at the end of two, four and ten hours and at 9 a. m. each succeeding day for four days, these times having been discovered to be the most advantageous for demonstrating the maximum blood level. Urine and stool examinations were made daily on pooled twenty-four-hour collections. The mean concentrations of all determinations appear in Table I, arranged according to time.

Maximum blood levels were reached within four hours after the ingestion of a single dose, whereas maximum concentration in the stools was found on the second and sometimes on the third day. This concentration rapidly diminished and became imperceptible before the drug had disappeared from the urine. The persistence of sulfaguanidin in the urine long after it has disappeared from the blood and stools in quantities measurable by routine methods suggests that small amounts of the drug may be excreted from time to time over prolonged periods, from stores which have accumulated in the body. This is further suggested by the fact that in no instance were we able to recover all of the drug given by mouth. One person excreted 2.88 grams but the others excreted between 30 per cent to 66 per cent of the original dose. The conclusion is that a con-

1. Marshall, E. K.; Bratton, A. C.; White, H. J., and Litchfield, J. T.: *Bull. Johns Hopkins Hosp.*, 67:163, Sept., 1940.

2. Marshall, E. K.; Bratton, A. C.; Edwards, L. B., and Walker, E.: *Bull. Johns Hopkins Hosp.*, 68:94, Jan., 1941.

3. Lyon, George M.: *West Virginia Med. Journ.*, 37:54, Feb., 1941.

*The sulfaguanidin for this study was supplied by the Research Department of the Lederle Laboratories.

4. Bratton, A. C., and Marshall, E. K.: *Journ. Biol. Chem.*, 128:537 (1939).

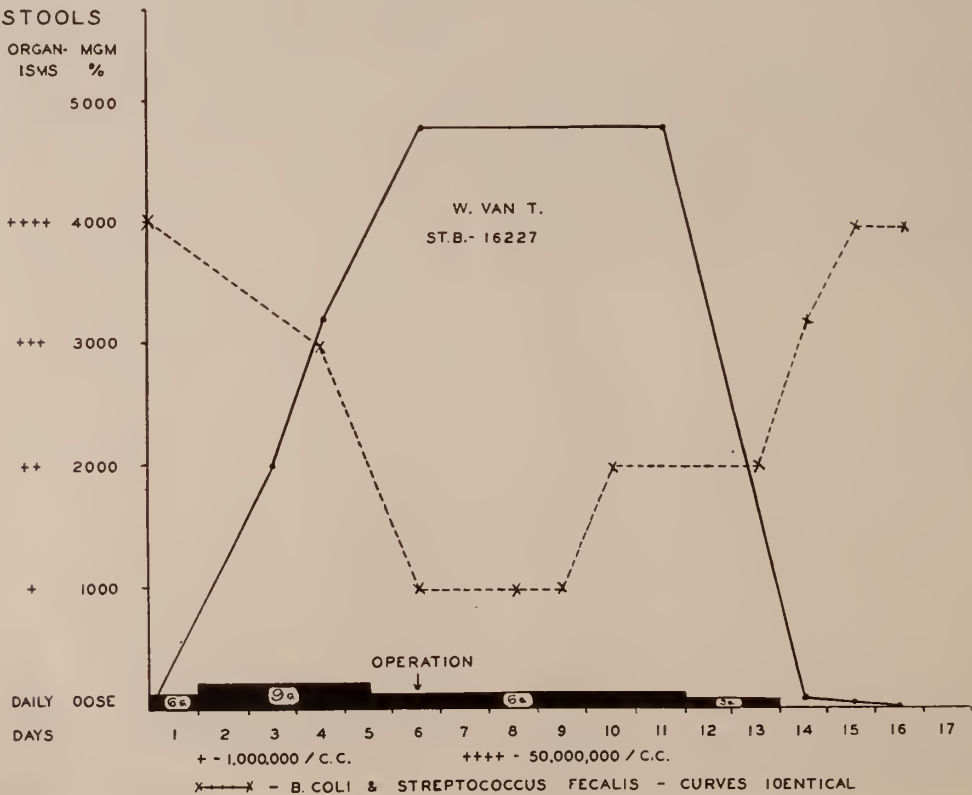
TABLE I.

MEAN CONCENTRATION—7 CASES—SINGLE 3 GM. DOSE OF SULFAGUANIDIN

Day and Time	BLOOD			URINE			STOOLS		
	Free	Total	% Conj.	Free	Total	% Conj.	Free	Total	% Conj.
1st 10 A. M. 12 N. 6 P. M.	0.93	1.24	25.00	.....	.....	.....	.....	.....	.....
	1.70	2.11	19.4	.....	.....	.....	.....	.....	.....
	0.60	0.73	17.8	31.60	39.94	20.8	123.45	133.92	7.8
2nd 9 A. M.	0.075	0.174	56.8	17.30	28.58	39.4	136.80	172.40	20.6
3rd 9 A. M.	0.00	0.00	.....	7.80	12.61	38.2	87.22	91.50	4.6
				3.96	6.20	36.2			
4th 9 A. M.	0.00	0.00	.....	2.50	4.42	43.4	1.33	1.40	5.0
				1.31	2.37	44.7			
5th 9 A. M.	0.00	0.00	.....	1.12	1.85	39.5	0.00	0.00	.....
				0.90	1.45	37.8			

siderable portion of the drug was retained within the body. Sulfaguanidin also behaved like other sulfanilamid derivatives in that the proportion of acetylation increased the longer the drug remained in the circulation. Highest concentration of the drug in the stools was 436 milligrams per cent and the lowest, 35 milligrams per cent. All stool specimens with a concentration over 100 milligrams per cent

showed decreased colony counts for the colon group of organisms when plated out. In no instances did the count fall below 1,000,000 bacteria per cubic centimeter. Several specimens came within the limits of 1,000,000 to 3,000,000 per cubic centimeter, having fallen to this number from 5,000,000 to 50,000,000 before medication. The anaerobic bacteria were inconclusively influenced.



MULTIPLE DOSES

Ten adult patients were given 3 grams of sulfaguanidin every eight hours for periods of six days to two weeks. Their blood, urine and stools were studied in the manner outlined for persons receiving a single dose. The arithmetic means of all the determinations made, with the percentages of conjugation, are presented in Table II.

TABLE II.

MEAN CONCENTRATION—SULFAGUANIDIN

10 CASES—3 GRAMS EVERY 8 HOURS

	Free	Total	% Conj.
Blood	1.54	1.82	15.4
Urine	90.4	105.3	14.0
Stools	1000.0	1140.0	12.4

It is evident that high concentrations of sulfaguanidin can be obtained in the stools with very low levels in the blood. While it might be thought that these low levels were due to minimal absorption from the gastrointestinal tract, the average concentration in the urine suggests that more than small amounts of the drug were absorbed and that it was excreted very rapidly, retained in part, or both. We have noted concentrations of total sulfaguanidin in the urine varying from 25 milligrams per cent to 200 milligrams per cent with associated total blood concentrations within the narrow range of 1.5 to 1.8 milligrams percent. The single dose series indicates that there was some retention of the drug by the body. The multiple dose series demonstrates this more conclusively. The greatest amount of drug recovered approached 65 per cent, in a woman with diarrhea accompanying ulcerative colitis. Most of the other patients excreted from 29 to 40 per cent of the drug up to the time when no free or acetylated drug could be detected in the blood, urine or stools.

Several rabbits were fed sulfaguanidin, 1 gram per kilogram of body weight, and then killed. Microscopic sections of the kidneys did not reveal any crystals or damage to the tubules or glomeruli. Sections of the other organs were apparently normal.

EFFECT ON BACTERIA

Sulfaguanidin had marked effect against organisms in the human stool as shown by daily cultures and colony counts. The most profound effect was against the colon bacillus group, which was reduced to very small numbers and occasionally eliminated by high concentrations of the drug in the stools. It was comparatively easy to bring about reduction of organisms to 1,000,000 per cubic centimeter but difficult to accomplish such complete sterilization that no colonies were detected. The latter was achieved but once after administration of 3 grams every eight hours for twelve days. The highest concentration of total drug in this patient's stool was 4000 milligrams per cent. Other patients exhibited concentrations up to 4800 milligrams per cent with 1,000,000 bacteria or less per cubic centimeter. This concentration did not seem to be sufficient to eliminate the colon bacilli. *Streptococcus fecalis* and alpha streptococcus were much reduced. After about six days' treatment the colonies of alpha streptococci became very small and grew with difficulty. The anaerobic cocci and bacilli were inconstantly affected and fluctuated in numbers while high concentrations of the drug in the stools were maintained. Figure 1 illustrates the reduction of colon bacilli and streptococcus fecalis in a patient who underwent a surgical operation on the sigmoid colon. We were unable to observe any close correlation between the levels of either free or total drug in the blood and urine with the levels in the stools. High blood levels occurred at the same time as low stool levels and vice versa.

THERAPY AND REACTIONS

Nine patients with ulcerative colitis were treated. Three were improved. One patient had bloody stools, edematous mucous membranes in the rectum and sigmoid colon, and many ulcerations. These improved after twelve days' treatment and all bleeding ceased. When examined later, the ulcers were small and the mucous membranes were much less swollen. Another patient experienced similar relief and exhibited a reversal of her differential leucocyte count in that a relative lymphocytosis changed into a normal differential count with

a predominance of polymorphonuclear leucocytes within one week. We are unable to draw any conclusions regarding one case of diverticulitis or two operative colon cases except to state that a substantial reduction of the intestinal flora was obtained and that this reduction of the number of organisms may have had a favorable influence on the postoperative course.

Reactions to sulfaguanidin were few. One patient became slightly nauseated and lost her appetite after six days' therapy. The erythrocytes and hemoglobin of another patient dropped abruptly after he had taken 4 grams

SUMMARY

Seven apparently normal persons were given single doses of 3 grams of sulfaguanidin. Determinations were made of the free and total drug in the blood, urine and stools. The mean concentrations are presented in table form with percentages of conjugation.

Ten adults were given 3 grams of sulfaguanidin every eight hours for periods of six days to two weeks. Determinations were made of the free and total drug in the blood, urine and stools. The mean concentrations and percentages of conjugation are presented in table form.

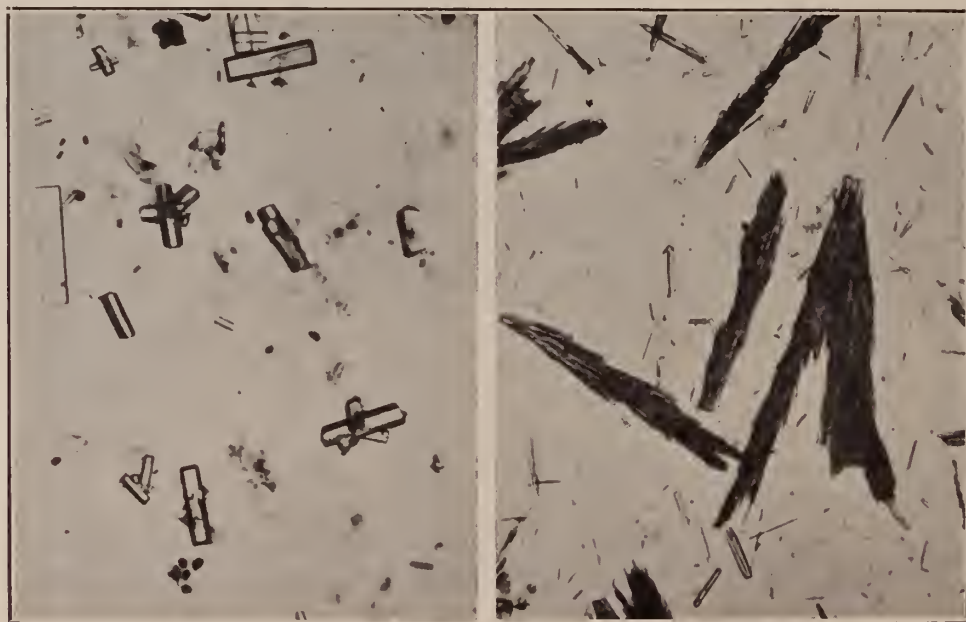


FIGURE 2

Left—sulfaguanidin. Right—acetylsulfaguanidin; crystals from urines of patients treated with sulfaguanidin orally.

every four hours for several days. Several weeks later he tolerated 3 grams every eight hours without any reaction. Two other patients became very irritable, tired and lost their appetite. Crystals of sulfaguanidin and acetylsulfaguanidin were seen in the urine of all treated patients. See Figure 2. In some instances only the acetylated form was discovered. Crystals appeared in great numbers whenever the urine was cooled or allowed to stand for a prolonged period. No diminution of renal output was noticed.

Excretion of sulfaguanidin in terms of the total ingested dose ranged from 29 to 66 per cent with the exception of one case, in which it was 96 per cent. The excretion was less when multiple doses were given and the relationship between excreted and unexcreted portions are shown in graph form. Rabbits were fed sulfaguanidin and sacrificed. Microscopic sections of the kidneys did not reveal any deposition of crystals or damage to the glomeruli or tubules. Other organs appeared normal.

Sulfaguanidin is effective in reducing the number of colon bacilli in the stools, if concentrations of total drug amounting to at least 1000 milligrams per cent are maintained for six to nine days. Higher concentrations, 3000 to 5000 milligrams per cent, may produce the same results within five to six days. Streptococcus fecalis and alpha streptococci may be effectively reduced in some cases. The anaerobic bacteria are inconstantly influenced. The relationship between stool concentrations of sulfaguanidin and the intestinal flora is depicted in graph form.

Although blood level determinations are essential to check absorption and efficiency of renal excretion in each case, these levels are not necessarily correlated with or indicative of the levels in the stools.

Three cases of ulcerative colitis were improved by sulfaguanidin therapy. Nine were not improved. Two operative colon cases did very well during their postoperative course. This may have been due to the reduction of the colon bacilli in the stools during the preoperative and postoperative period.

The following reactions to sulfaguanidin were noted:

1 case, nausea	5.5%
3 cases, anorexia	16.5%
1 case, reduction in hemoglobin and erythrocytes	5.5%
2 cases, malaise and irritability	11%

Crystals were found in the urine of all patients. Renal output was not diminished. The types of crystals are illustrated.

111 Clinton Avenue, Newark
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PSYCHOSES IN THE AGED

The mental disorders of the aged are almost as amenable to treatment as those of younger patients, according to Dr. G. Wilse Robinson, Jr., who recently wrote in the J. A. M. A.:

"In the days of straight pathologic interpretation, this branch of medicine was neglected almost entirely because of the belief that arteriosclerosis and senile atrophy were the sole and only causes of the symptoms.

"Senile organic changes are both progressive and irreversible. If the changes were causing the symptoms, the only thing for the physician to do would be to control the symptoms, and the only objective of society would be to provide care and custody for those whose mental faculties have been disturbed by these developments. These concepts have led to a pessimistic outlook and to a disinterest in geriatrics as a constructive branch of therapeutics.

"The most distressing developments of old age are the mental symptoms. If the mental symptoms are interpreted as straight pathologic developments they are all hopeless, and every person over 60 who acquires mental symptoms should be confined immediately to an institution and considered to be in need of custody and protection the rest of his life.

"The mental states of persons over 60 who present symptoms of an abnormal mental state must be analyzed in terms of total psychiatry rather than of pathology alone.

"Three years ago I began to treat patients with these disorders intensively by every known means (psychiatry, internal medicine, shock treatment and other measures). We decided that every patient was entitled to a chance and that a hopeless prognosis would not be given until every possible therapeutic aid had been exhausted. Since then we have studied and treated 50 patients over 60 years of age. * * *

"Thirty-five patients, or 70 per cent, of our total series recovered sufficiently to return home. * * * Of the 36 patients who had conditions that should be expected to respond to psychiatric therapy 69 per cent recovered completely while 22 per cent had a remission of sufficient quality to enable them to go home. This gives a percentage of 91.6 of the group with a reversible type of psychosis who were able to take care of themselves rather than be confined to an 'institution' for the rest of their lives. These figures do not bear out the usual hopeless prognosis held for patients with mental disorders over 60. * * *

AN UNORTHODOX BUT EFFECTIVE TREATMENT OF SCARLATINA

By LAWRENCE H. ROGERS, M.D.

Medical Superintendent of the Donnelly Memorial Hospital, Trenton, N. J.

Many years of observation on hundreds of cases of scarlatina, with unsatisfactory clinical results attained by following classical or textbook treatment methods, have convinced me that the accepted views on scarlatina and its therapy are obsolete.

PATHOGENESIS

I believe that scarlatina is due to a *focal infection* caused by the *Streptococcus Hemolyticus*. In the usual type, the focus is in the nasopharynx. Absorption of toxin from this focus causes the complications of the disease, such as cervical adenitis, arthritis, nephritis, etc. Ear infection is caused by the passage of infected throat secretions through the Eustachian tube via continuity of tissue.

In the less frequent but more fatal disease known as "surgical scarlatina", the focus of infection is in a wound. It usually begins as a burn, postpartum wound, or surgical or traumatic injury from which the characteristic punctiform eruption spreads over the body.

TREATMENT

On this concept of focal infection the therapy is based. My primary aim is to disinfect the local focus of disease to prevent absorption of toxins and the dangerous complications which result from toxin absorption. I use 10 per cent argyrol solution in the nose three times a day, instilled with the patient lying on his back until he expectorates it. Ephedrin jelly is employed to constrict the nasal passages in order to facilitate drainage. In many severe cases, nasal obstruction is marked, and purulent nasal discharge is profuse. Multiple infection of the nasal accessory sinuses is common. In this type of case, I have had satisfactory results from the stock streptococcus, staphylococcus and pneumococcus vaccines.

In severe throat infections patients cannot expel the toxic secretions by coughing or swal-

lowing because of the intense pain caused by such efforts. These secretions must be removed mechanically to prevent absorption. I use hot throat irrigations every hour P. R. N. plus an ice collar and encourage the patient to swallow some of the solution to prevent dehydration. It is important to use non-poisonous medicaments in the solution; for example:

R Sod. Bicarb.
Sod. Chloride—a.a. dr. 1
Aquae—q.s. ad. 1 ounce

The hot solution relieves the agonizing throat pain. When patients show evidence of dehydration due to high fever or dysphagia, use hypodermoclysis of saline—5 per cent dextrose solution, using a pint or more daily. Restrict the diet to fluids for at least a week. The patient should be kept warm in bed until a few days after the temperature has reached normal.

RESULTS

To measure the correctness of this treatment, I can cite mortality rates of almost zero. Complications were absent or mild, and none required radical surgical intervention. None of the mastoid complications, for example, ever needed operation; x-ray treatment cleared the mastoiditis in the few cases in which it developed. Seldom have I seen a suppurating gland and never a suppurating arthritis. Nephritis has seldom developed and has always been mild. In surgical scarlatina, I use local disinfection of the wound and scarlet fever antitoxin. For the ordinary pharyngeal type of scarlatina, I abandoned scarlatina antitoxin after two years of trial. More and severer complications occurred with it than without it. Many patients developed serum sickness after its use. I have had no deaths in surgical scarlatina since using the antitoxin in six cases. Previously, all of this type died. Before sulfanilamid was available, we had no deaths in 1200 cases (excluding five patients, moribund on admission).

Sulfanilamid was of great value in severe scarlatina. In ordinary cases, we did not need it. As a temporary means of prophylaxis for contacts, we have used sulfanilamid in the Trenton Board of Health for over two years. So far, no contacts have developed the disease while using it. I advise 30 grains daily for an adult for five days. Of course it is never to be used except under a physician's observation.

EPIDEMIOLOGY

We believe from our experience that we can hereafter control severe epidemics of the disease. We have not been impressed with the prophylactic use of scarlet fever antitoxin, and no longer use it for this purpose. Many persons developed scarlatina after its use and serum sickness was frequent.

COMPLICATIONS

In treating scarlet fever, I noticed that most deaths were due to preventable complications, dehydration, or non-recognized complicating disease, notably diphtheria. We exclude the latter by smear or culture from the nose and throat of every patient admitted. In some years we have found scarlatina and diphtheria coexisting in 5 to 20 per cent of all cases admitted. I believe that streptococcic sore throat and scarlatina are the same disease, except for

the skin eruption. Both are contagious and are accompanied by the same complications. I have often seen a streptococcic sore throat develop in one patient while a few days later a member of the household developed a sore throat with the characteristic punctiform skin eruption which we call scarlatina. I think that streptococcic sore throat cases should be reported to the Board of Health just as scarlatina now is.

TREATMENT OF ERYSIPELAS

For many years we have used diphtheria antitoxin in the treatment of erysipelas. We give 1000 units every 12 hours intramuscularly until the eruption ceases spreading and the patient's condition improves. Rarely have we found it necessary to give a third dose. Our mortality from erysipelas is much lower than that reported from hospitals using other forms of treatment. We have tried them all but believe that diphtheria antitoxin is the best known treatment to date. It is not costly and is available in almost any locality.

Editorial Note: Dr. Rogers characterizes his approach as "unorthodox". The editor, and we are sure, the author, would appreciate comments from readers about the treatment techniques outlined in this paper.

Donnelly Memorial Hospital

CONTROL OF GONORRHEA

According to Pelouze in a recent article in The Journal of the Michigan State Medical Society, we are on the way towards the control of gonorrhea. "Sulfanilamid is so inferior to both sulfapyridin and sulfathiazole that it should not be used in the treatment of this disease. Sulfathiazole is superior to the other two and is the drug of choice. It has a higher cure rate and is far less toxic. Like the other sulfanomids it cures some, leaves some as asymptomatic gonococcus carriers and fails utterly in others. An efficient course extends from 7 to 10 days and requires no more than

25 grams of the drug. If the patient is not symptom-free in 5 days he can be considered a sulfonamid failure. Sulfathiazole frequently will produce cure where other derivatives have failed.

"Because of the danger of carrier states, cultures are of the utmost importance as tests of cure and patients should be kept under observation for, probably, two months after seeming cure."

Sulfathiazole is also the drug of choice in the female.

A NEW METHOD IN THE SURGICAL TREATMENT OF HEMORRHOIDS

By HARRY E. BACON, M.D., F.A.C.S., Philadelphia, Pennsylvania
Clinical Professor of Proctology, Temple University School of Medicine

While surgical methods for the removal of hemorrhoids are often inadequate and unsatisfactory, it must be realized that there is not, and probably never will be, a procedure perfectly adapted for each and every type of hemorrhoidal excrescence. Post-operative pain of severe intensity, hemorrhage, immediate and remote, anal stenosis, residual infection, abscess formation, fissures and recurrence of the hemorrhoids themselves are sequelae that are encountered following the various technics as usually performed. The occurrence of these sequelae is, for the most part, due to lack of knowledge of the anatomy of this portion of the anorectum, and the pathologic process itself, unnecessary trauma, failure to preserve adequate anal and perianal skin, inclusion of the sphincter muscle in the suture and clamp, employment of large suture material, the use of abusive drains and packs and inadequate after-care.

The lower rectum and anal canal must be considered as a narrowed tube, purse-stringed in effect by the sphincter musculature. Its architecture and the character of the lining membrane—modified skin (squamous epithelium)—thereby favors untoward sequelae where undue surgical distortion is instituted.

Because of the severe post-operative pain following hemorrhoidectomy, a technic was devised by us which has proved of great value, not only in the avoidance of pain, but also in the elimination of complications and sequelae. The procedure¹ was reported only after its performance on over a thousand patients.² This technic has now been used on 1682 patients.³ In this series the frequency of severe post-operative pain is less than 8 per cent; anal stenosis occurred in 12 cases (.007 per cent),

subcutaneous abscess in five cases (.003 per cent), fissure in one case. No cases of hemorrhage, incontinence, or recurrences have been noted.

PROCEDURE

Under low lumbar analgesia, the dosage being estimated according to the body weight,⁴ and with the patient in the jackknife position,

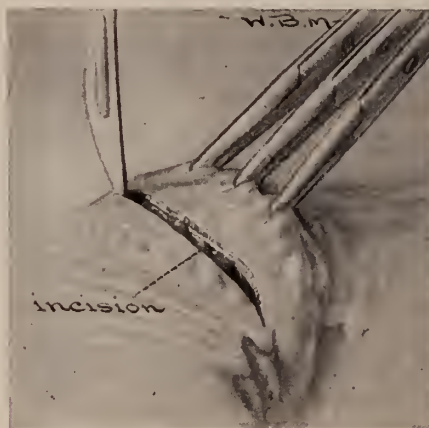


FIGURE 1.

Incision in skin high on lateral wall of the hemorrhoid, beginning at the anorectal line.

the sphincters are divulsed and the anorectum cleansed. The gloves used for the analgesia and divulsion are discarded; the operator dons sterile gown and gloves and the perianal region is prepared. After appropriate drapes are in place, a Smith retracting speculum is introduced and the pile masses are drawn outside the anus in their respective quadrants by means of curved Rankin hemostats (Figure 1). Additional hemostats are applied to the hemorrhoids to bring into view as much tissue as possible without undue tension. If external hemorrhoids are present, a small elliptic incision is made on the lower lateral side of each hemorrhoid in such a manner that it begins at a point just distal to the anorectal line and carried one-

1. Bacon, H. E.: Anorectal operative procedure with especial reference to the avoidance of pain. *Jour. Amer. Med. Assn.*, 116:363 (Feb. 1) 1941.

2. Bacon, H. E.: *Anus, Rectum, Sigmoid Colon*, 2nd edit. 1941, J. B. Lippincott Co., Phila., p. 501.

3. Bacon, H. E.: Improved technic of hemorrhoidectomy. Read before National Gastroenterological Assn. (May) 1941.

4. Bacon, H. E., and Lindig, H. C.: Lumbar analgesia in anorectal surgery. *Trans. Amer. Proctol. Soc.*, p. 253, 1940.

half inch beyond the tip of the external pile mass. The skin on either side of the hemorrhoid is elevated with fine forceps and the underlying tissue separated with small, blunt-tipped curved scissors. The opposite side of the pile mass is treated in a similar fashion.

The hemorrhoid is now elevated and blunt dissection is begun at the apex where the two incisions are joined. The adjacent veins, which have been freed on either side, are now drawn medially by an assistant and the operator continues with the blunt dissection on the surface of the external sphincter muscle (Figure 2). When the inner edge of this muscle is encountered, a small right-angle retractor is placed so as to draw the muscle gently from the field of operation. A Smith hemorrhoidal clamp is now



FIGURE 2.

By means of small curved scissors the subcutaneous veins are separated for preservation of the skin.

placed on the hemorrhoidal mass in the longitudinal axis of the bowel and cut away (Figure 3). A suture of No. 0 chromic catgut on a small curved needle is introduced one-quarter inch from the tip of the clamp and tied, the free end to serve as an anchor (Figure 4). The base of the hemorrhoid is sutured beneath the clamp from side to side and continued to the opposite end of the hemorrhoidal base which lies immediately over the edge of the external sphincter muscle. The clamp is removed as well as the retractor and the muscle permitted to return to its usual location. A subcutaneous bed is formed by continuing the suture to the outer limit of the apex.

All hemorrhoidal masses are treated in a

similar fashion. Ordinarily it is unnecessary to approximate the cut edges resulting from the excision of external hemorrhoids, inasmuch as they fold nicely together as soon as the tonicity of the sphincter is restored. However, we do not hesitate to insert two or more sutures of black silk or No. 35 steel alloy wire interruptedly. Ten cubic centimeters of diothane are injected into the substance of the sphincter muscle through a single puncture in the posterior midline behind the anal verge. A cellophane drain, consisting of a four-inch, No. 14 soft rubber tube, surrounded by a strip of wet cellophane, is introduced and dressing applied.

POST-OPERATIVE CARE

Immediately on the patient's return to his room, the foot of the bed is elevated for six hours, where a hypobaric (light) analgesic solution is used intraspinaly. Liquids, a light soft diet and smoking are permitted. Compresses wrung out in hot boric acid solution are applied continuously. At night these may be supported by a hot water bottle. Morphine sulphate in $\frac{1}{4}$ grain (0.01 Gm.) doses or dilaudid gr. $\frac{1}{20}$ is given only if necessary. Blood pressure is read every hour for six hours in both arms. Twenty-four hours after operation the cellophane tube drain is removed and an aqueous solution of 1 per cent gentian violet applied on a glass rod. Liquid petrolatum is given by mouth once or twice daily and continued for approximately ten to fourteen days. On the second post-operative day, an enema of warm saline or olive oil is administered through a 14 soft rubber catheter. Milk of magnesia ounces $\frac{1}{2}$ to 1 is given by mouth thereafter. Following bowel movement, the patient is permitted out of bed, a house diet is prescribed and hot sitz baths thrice daily, at a temperature of 110° F. and a depth of six inches for ten minutes, are begun.

When discharged on the third or fourth post-operative day, the patient is advised to continue with the sitz baths, employ cotton tissue rather than toilet paper and have one daily evacuation. Skin sutures are removed on the fifth to the seventh day, at which time the lubricated gloved finger is introduced.

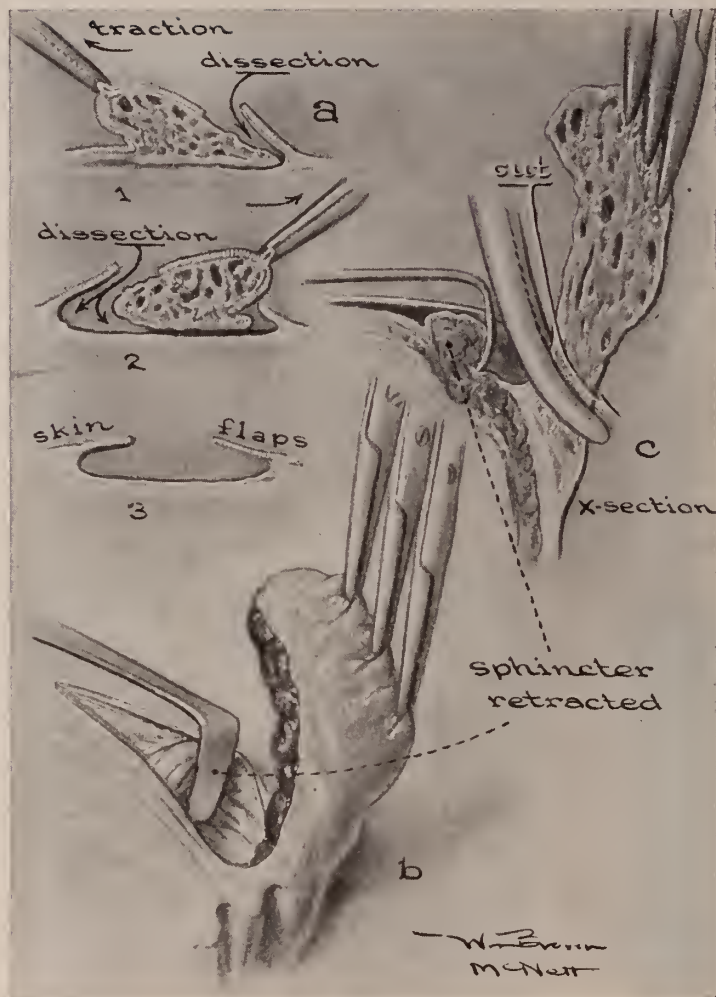


FIGURE 3.

- a-1—Manner in which the subcutaneous veins and tissue are separated from anal and perianal skin; a-2, posterolateral wall similarly treated; a-3, wound after hemorrhoid and all subcutaneous veins have been freed and drawn medialward.
- b—The hemorrhoid and subcutaneous veins have been dissected free on and above the surface of the external sphincter muscle and the latter is retracted.
- c—Muscle retractor in place; Smith clamp applied in longitudinal axis. Arrow shows line of incision.

FIGURE 4.

- a—Anchor suture placed in mucosa immediately above excised internal hemorrhoid. Suture continued beneath the clamp to anorectal line when clamp is removed. Subcutaneous bed beneath anal and perianal skin is continued.
- b—Distal portion of skin is approximated with black silk or number 0.35 alloy steel wire.

CONCLUSIONS

Two distinct advantages are afforded through this technic: more hemorrhoidal tissue can be removed through preservation of the anal and immediate perianal skin, and any degree of mucous prolapse which is invariably present may be included in the distal portion of the clamp. The procedure is designed on an anatomic basis in cognizance of the existing pathologic process. Of the end-results, the incidence of pain has been exceedingly low and the sequelae and complications almost nil.



WHAT ARE DECIBELS? A PAINLESS ANALYSIS

By J. J. ROTH, M.D., Newark, N. J.

The use of decibels as a means of recording hearing acuity is the standardized method of today. But what are decibels? How do they measure hearing acuity or hearing loss? These questions are frequently asked by the general practitioner. The following explanation has been prepared for the non-specialist, and will be, so far as possible, free from technical description or higher mathematics.

Whereas the recording of visual acuity has been so well standardized that it has been comprehensible even to the layman for many years, no such universal understanding has ever been reached with regard to hearing. The introduction of the pitch audiometer was the first step in this direction. Prior to that time there was much confusion in the ranks of otologists. The ordinary watch, the spoken or whispered word, the siren and similar devices were crude make-shifts. They served as a guide for the records of an individual examiner; that was all. All attempts to express hearing acuity (or rather loss of acuity) by an ordinary fraction analogous to the classical 20/20 of visual defects were dire failures. The otologist, who frequently was also engaged in ophthalmology, could not extricate himself from the rut of fractional thinking.

THE "THRESHOLD" CONCEPT

The problem therefore had to be approached from a fresh point of view, and was eventually solved by a group of workers free from such prejudice. The progress of radio brought forth the sound engineer. With his superior knowledge in the highly specialized field of acoustics, he was able to set the problem in its proper perspective. What, he asked, is the faintest sound just audible to the normal ear of a young adult? Once such a sound is reproduced in the different pitches of the speech range, you have established what may be called the threshold of normal hearing. As the deafened subject is unable to hear such faint sounds, it will be

necessary to amplify them, so as to render them audible to him. The amount of amplification required furnishes us a perfect yardstick for the degree of deafness. Or, putting it in a simpler way, how many times must the threshold sound be amplified to make it audible to the deafened subject? This is our problem; it is the basis of all audiometric measurements.

Since the threshold sound is very faint, the degree of amplification required will often have to be very high; and in the markedly deafened actually enormous. Under such conditions, a report on a hearing test might read something like this: Right ear: amplification required, 20,000; left ear: amplification required, 100,000. Such reporting would be perfectly intelligible, in spite of the fact that most of us have but a very vague conception of what such enormous amplifications may actually mean. Thus, the fact remains that high, almost astronomic figures would have to be used. To be sure, physicians speak of counting millions of red blood corpuscles and injecting millions of units; but these are strictly medical terms. No engineer ever collaborated here. On the other hand, engineers, like physicists and mathematicians, seem to have an actual aversion to unusually high figures, and whenever called upon to deal with them, they immediately set out to reduce them to their minimum equivalents. Such minimum equivalents are their logarithms.

DEFINING THE DECIBEL

A definition of decibels can now be given. They are logarithmic expressions of the amount of amplification required in order to make the threshold sound audible to the deafened ear. We say "expressions", not "equivalents". Were we to substitute the latter for the former, the definition would have to be amended to read: Decibels are the logarithmic equivalents of the amount of amplification required—multiplied by ten. This multiplication by ten becomes

necessary because decibels are not the units of our measuring system, just as dimes are not the units of our monetary system. Decibels, as the name implies, are tenths of a unit, the *Bel* being the unit. As this unit, however, is somewhat too large for our purposes, calculations are made in tenths of such unit. It is the Bel that represents the common logarithmic equivalent of amplification; hence, ten times this equivalent when figuring in decibels.

WHAT IS A BEL?

The peculiar nature of this unit requires some further study. How does it act, and how does it measure sound? Contrary to what many think, the Bel is *not* a unit of sound intensity. It represents no sound of a certain loudness. On the contrary, the bel is a unit of *relative* sound intensity between two sounds. There is a difference here. With a unit of absolute sound intensity, one unit would represent a certain degree of loudness, two units twice that loudness and so on, as is the case with yards and meters. On the other hand, a unit of relative sound intensity measures *how much louder is one sound when compared to another*. In short, we are dealing with a unit of sound intensification, or as usually called, *amplification*.

Now then, how much does a Bel amplify? The answer is, ten times. Any given sound, soft or loud, is amplified ten times upon the application of one Bel. It must not, however, be supposed that two Bels will amplify 20 times, and three Bels 30 times. On the contrary, the application of a second Bel will amplify the resultant sound again ten times, which means that the original sound will be amplified 100 times, and three Bels will accordingly give an amplification of 1000. The grasping of this principle is essential to the proper understanding of the working of decibels and their meaning. We are simply not dealing with arithmetical proportions, the Bel being unlike most of our measuring units not an arithmetical but a logarithmic concept.

PAINLESS LOGARITHMS

This reference to logarithms need not awaken thoughts of mysterious and intricate tables; no brushing up on them will be required; not even

a definition shall be given. For our purposes it will be sufficient to know that logarithms are abbreviated symbols of larger numbers, and that any number beginning with figure 1 and followed by one or more zeros will have as its common logarithmic equivalent the sum of the number of such zeros. For example:

10	having	1	zero,	its	log.	equals	1
100	"	2	zeros,	"	"	"	2
1,000	"	3	"	"	"	"	3
1,000,000	"	6	"	"	"	"	6
1	"	0	"	"	"	"	0

By reversing the above and applying it to our measuring unit, the Bel (B), it follows that:

- 1 being the log. of 10
1 B represents an amplification of 10
- 2 being the log. of 100
2 B represent an amplification of 100
- 3 being the log. of 1,000
3 B represent an amplification of 1,000

Or substituting decibels (db) for Bels,

10 db	represent	an	amplification	of	10
20 db	"	"	"	"	100
30 db	"	"	"	"	1,000
60 db	"	"	"	"	1,000,000

The simplicity of obtaining exact answers to a round number of decibels, such as 10, 20, 30, 40 and so on, becomes apparent.

INTERMEDIATE VALUES

But what about the in-between values? If 20 db amplify 100 times, and 30 db, 1000 times, do 25 db give a proportionate amplification of 500? Of course, not; the values and proportions are not arithmetical. One Bel, to be sure, amplifies ten times, but one db, which is the tenth part of a Bel, amplifies no more than a little over 25 per cent (to be exact, 25.9 per cent). This round percentage (of 25) again helps considerably in facilitating calculations of the in-between values from 1 to 9, without the use of logarithmic tables. We shall proceed as follows:

- For 1 db—add 25%.
- 2 db—add another 25%, or 55% in all.
- 3 db—multiply by 2, as compounding three times at 25% doubles the original value.
- 4 db—multiply by 2.5; same as adding another 25% (to 2).
- 5 db—multiply by 3 (plus); same as adding another 25% (to 2.5).
- 6 db—multiply by 4. Why 4? If 3 db doubles, then 6 db redoubles.

- 7 db—multiply by 5; same as adding another 25% (to previous 4).
8 db—multiply by 6; 3 db doubles, and 5 db triples the double.
9 db—multiply by 8; 3 db doubles, 6 db re-doubles and 9 db will double the re-double.

If all this sounds a bit complicated, a few practical examples may serve to clear up matters.

Example No. 1.

The hearing acuity being 16 db, what loss do they represent?

- 16 db equal 1 B+6 db.
1 B amplifies 10 times
6 db double twice, i. e. multiply by 4

Answer: 40 times amplification. Or putting it differently, a 16 db hearing loss calls for an amplification of 40 times the strength of the threshold sound in order to make it audible to the deafened ear.

No. 2.

- 23 db=2 B+3 db.
2 B amplify 100 times (1 followed by two zeros)
3 db double the value

Answer: 200 times.

No. 3.

- 35 db=3 B+5 db.
3 B amplify 1000 times (1 followed by three zeros).

5 db triple the value

Ergo: the amplification is 3000.

No. 4.

41 db=4 B+1 db.

4 B amplify 10,000 times (1 followed by four zeros).

1 db raises the value 25%

Result: 12,500.

Similarly 44 db will mean an amplification of 25,000, and 69 db one of 8,000,000.

This method gives results sufficiently accurate for most purposes. The 25 per cent increase for each decibel eliminates the need for memorizing any special table.

RULE OF NINE

As a guide to the evaluation of the degree of hearing loss the following *Rule of Nine* may be suggested. Disregard all losses up to 9 db, inclusive; they are to be considered within normal variations. From 10 to 18 db, the loss is slight. From 19 to 27 db the loss is moderate. Losses of 28 db and over are marked.

One more thought: The logarithmic nature of the Bel and decibel proves conclusively how meaningless it is to express hearing loss on a percentage decibel basis. Considering the enormous difference between a 10 and a 30 decibel loss—the one being practically within normal limits, the other denoting a marked defect—the futility of all such attempts becomes only too apparent. Hearing acuity with its enormous range can not be expressed on any percentage basis, surely not on a percentage decibel basis.

31 Lincoln Park

SYMPATHETIC OPHTHALMIA

A case of sympathetic ophthalmia is described by Don Marshall, M.D., in a recent issue of The Journal of the Michigan State Medical Society in which a complete cure was obtained in the uninjured eye by the standard treatment of typhoid vaccine fever therapy, salicylates, local heat and atropine. The most

important therapeutic measure is prevention, and the most definite is early enucleation of the injured eye, but this radical step often is not justified. The prognosis is serious, but better under intensive therapy than is generally believed.

THE TREATMENT OF SEPTIC THROMBOPHLEBITIS WITH HEPARIN AND SULFATHIAZOLE

By HAROLD S. DAVIDSON, M.D., F.A.C.P., Atlantic City

Read before the American Therapeutic Society at Cleveland, Ohio, June 2, 1941

Heparin, discovered in 1916 by Howell and Holt, is obtained from liver, lung and muscle of the ox or dog. Dog liver contains about twice as much heparin as ox liver.

According to all available evidence, heparin is the product of certain specialized cells occurring in a wide variety of species, which eventually enters the blood stream where it acts as the physiologic anticoagulant. Mason¹ has published an excellent review of the history, chemistry, physiology and clinical application of heparin.

Most of the clinical use of heparin as an anticoagulant has been in blood vessel surgery. By increasing the clotting time by continuous intravenous administration of heparin in saline solution, the proportion of successes in arterial anastomoses has been markedly increased. Venous grafts, which invariably became occluded when heparin was not used, remained patent when successful experiments were completed.

Heparin is non-toxic for man. It is not absorbed from the alimentary tract.² In blood transfusions heparin is used satisfactorily, either by adding the drug to the blood as it is withdrawn, or by giving the donor a sufficiently large dose to change the clotting time of his blood.

The heparin provided by the Connaught Laboratories in Toronto is obtained from ox lung, the yield per hundred pounds being about one gram of the purified crystalline barium salt. The purified product has a potency of 100 units per milligram. The heparin used in the cases reported in this paper was obtained from the Roche-Organon Co. under the name of Liquaemin. It is packaged in 5 cc. vials, each containing 10,000 anticoagulant units. The potency of the two brands is not comparable. The American product is measured in Howell

units, which is the amount of heparin which prevents clotting of 1 cc. of cat's blood for 24 hours. The Connaught Laboratory unit is the potency of 0.01 milligramme of purified crystalline barium salt, and has about five times the activity of a Howell unit.

Heparin is probably the normal anticoagulant in circulating blood, and either assists or is necessary in maintaining blood in its fluid state. Its action may be largely to activate a precursor to antithrombin, rather than to combine with prothrombin or thrombin to make them insensitive to cephalin.³ The experimental work on heparin was undertaken with the hope that a preparation of heparin and a technic of administering it might be developed to improve the treatment of diseases in which thrombosis of blood vessels was an unsolved problem. Most of the earlier clinical work was on arterial anastomoses and on venous grafts, in which, when heparin was used and continued for not less than seven days, these vessels invariably remained patent. Since heparin has been available, twelve arterial embolectomies have been successfully performed by Murray.⁴

HEPARIN IN THROMBOPHLEBITIS

There are but few references in the literature concerning the use of heparin in septic thrombophlebitis. It was hoped that, if further extension of thrombosis could be prevented with heparin, the existing thrombus would become attached to the wall of the vein and complications such as embolism might not occur. There is no objection to the use of heparin in this condition, as it is not fibrolytic and would not tend to liquify the existing thrombus, but simply keep more thrombus from piling up. In one patient (Case No. 1), with a positive non-hemolytic streptococcic blood culture, sulfanilamid and sulfathiazole were given, in addition,

1. Mason, Morton F.; Heparin: Surgery, 5:451 (March); 618 (April) 1939.

2. Fisher, Albert, and Astrup, Tage: Proc. Soc. Exp. Biol. and Med., 42:82 (1939).

3. Murray, G. D. W.: Brit. J. Surg., 27:567.

4. Murray, D. W. G.: "Embolism in Peripheral Arteries", 1936. 35:61.

to sterilize the blood stream. This chemotherapeutic agent has been used successfully in septicemia.⁵ Ravdin and his associates have experienced such cases, as yet unpublished, and Champ Lyons has treated three cases at the Massachusetts General Hospital in which he used heparin to prevent clotting and sulfathiazole as a chemotherapeutic agent.

In the first case here reported, continuous heparinization was administered intravenously for nine days. No local venous thrombosis was encountered from the injection. Eighty-four 5 cc. vials were administered in normal saline solution. Clotting time was tested at the bedside night and morning by the capillary tube method and enough heparin added to the infusion to keep the clotting time between fifteen and twenty minutes. Generally, the concentration was a little more than 30 cc. per liter of fluid. The rate of flow was regulated to 30 to 40 drops per minute. At no time was there any edema or cardiac decompensation. In this instance the patient absolutely refused hospitalization, and the entire procedure was carried out at home with the help of two nurses.

As soon as a positive blood culture of the non-hemolytic streptococcus was obtained, sulfanilamid was administered. This drug was poorly tolerated. So much nausea and vomiting occurred that as soon as sulfathiazole could be obtained the newer compound was substituted. This was well tolerated; little nausea and no vomiting were reported, and sufficient nourishment by mouth was possible throughout the course of the illness. The red blood cell count and hemoglobin remained practically stationary during the entire illness, falling slightly as the disease progressed, and responding to a transfusion in convalescence. During the height of the febrile period occasional reports of five to ten milligrammes of albumin and a few hyalin casts were reported in the urine, but generally, the urine was clear and at no time were red cells found.

CASE 1

On July 4th, 1940, Mrs. I. F., age 47, consulted me because of pain in her right leg. Two days previously she had experienced a sharp pain in her right calf. She kept walking for several hours

and when she returned home her leg was very sore. A physician bandaged her leg. The next day she was no better and the bandage was reapplied. On the third day, she visited a friend in a hospital, and casually asked the friend's physician about her leg. He told her she had phlebitis and should be hospitalized at once. This she refused.

When I first examined this patient, her temperature was 98.4, pulse 96 and respiration 24. Examination was negative, except for the right leg, which presented a red indurated area, exquisitely tender to palpation, along the course of the popliteal vein. Blood count showed 71.4 per cent hemoglobin, 3,720,000 red cells, 9,050 leucocytes. Of these, 70 per cent were polymorphonuclears, 27 per cent were lymphocytes and 3 per cent were monocytes. There were 27 band forms and a marked shift to the left. Hospitalization was refused. The patient was warned of the danger, and a nurse employed.

During the night the patient insisted upon sliding over on the commode. She became chilly, dyspneic with weak and irregular pulse. Cyanosis was noted. A few râles were heard in the left base posteriorly. A surgical consultant found that the inflammation had extended along the course of the femoral vein to Pouparts ligament. The diagnosis was femoro-iliac thrombophlebitis, and surgical attack on the vein was discouraged. The temperature now rose to 102°, pulse 132 and respiration 26. The right leg became swollen and edematous. Sulfanilamid was poorly tolerated; there was constant nausea and frequent vomiting. Blood cultures by the quantitative technique were done on July 7, 10, 13, 15, 18 and 25. The first culture gave no growth. The second culture showed less than one colony per cc. of a Gram positive diplococcus in 48 hours, which, upon further study, proved to be a non-hemolytic streptococcus. In the third culture, planted on July 13th, two colonies of the same organism appeared in six days. The last three cultures gave no growth.

On July 9th a consultation with Dr. Thomas Fitz-Hugh of Philadelphia was arranged. Sulfanilamid was discontinued and sulfathiazole in equal amount was substituted. This was perfectly tolerated, and from this point on all nausea and vomiting disappeared, and food was given without difficulty. The patient, at the time, was delirious, and had a high fever. Intravenous heparin was started. The coagulation time was three minutes. Coagulation time was tested twice daily and the concentration of heparin adjusted to keep the coagulation time longer than 15 minutes. Daily urinalyses were made, and at no time were red cells discovered.

On July 18th, the red cells dropped to 3,030,000 and the white cells were 18,350, of which 72 per cent were polymorphonuclears, 24 per cent small lymphocytes, 1 per cent eosinophiles, 3 per cent monocytes, with a marked shift to left. On July 21, dullness was noted at left base. The chest was tapped and 25 cubic centimeters of thin straw-colored fluid, containing a large amount of fibrin, were removed. There were no bacteria in the smears, only a few small lymphocytes being seen. The cultures were sterile. Up to this point the patient had had a temperature of from 102° to 104½°.

5. Stirling, W. C.: Sulfathiazole: 2 cases of septicemia with recovery, *Journ. A. M. A.*, 115, 118, July 12, 1940.

On July 22, a transfusion of 360 cc. of blood was given, which was followed by a chill and rise in temperature. From this point on the temperature gradually declined and the patient markedly improved.

All subsequent cultures were sterile. Sulfathiazole was given continuously at the rate of 1 Gram every four hours for thirty days. The temperature became normal on the 43rd day.

When it is realized that many patients who succumb to a fatal pulmonary embolism show at necropsy previous non-fatal peripheral emboli, it is evident that adequate prophylactic and therapeutic efforts in these cases might have prevented death. For this reason, it is of greatest importance to recognize thrombophlebitis and non-fatal emboli, and to administer heparin promptly.

PROPHYLACTIC USE OF HEPARIN

The following cases illustrate the prophylactic use of heparin and sulfathiazole in patients in whom peripheral thrombophlebitis was recognized. Fever was present, but blood cultures were sterile. Heparin therapy was instituted to render the blood less coagulable and to prevent extension of the thrombus. Sulfathiazole was given for its bacteriostatic action and to sterilize the blood stream and abolish possible embolic accidents.

CASE 2

On October 10, 1940, R. T., age 53, fell down a flight of stairs, landing on her buttocks. Unable to walk, she was taken to the Atlantic City Hospital, where x-ray revealed a fracture of the descending ramus of the pubis on the left side. A body cast was applied.

On October 22, temperature abruptly rose to 101°, and subsequently fluctuated between 103° and 98°.

On October 24, swelling of the right leg was discovered, skin was shiny, and the leg was tender to palpation in the popliteal space. Sulfathiazole, one Gram every four hours, was given.

On October 30, the left leg became swollen. Heparin was administered intravenously, six vials to the liter of salt solution, 16 drops per minute.

Repeated blood cultures were sterile. The temperature ran a septic course with an abrupt decline on November 7. During the next ten days the temperature fluctuated between 100° and normal, and from then on remained normal. Heparin and sulfathiazole were discontinued. The swelling of the limbs had largely disappeared, leaving some residual soreness on palpation over the left saphenous vein. The patient remained in the hospital until January 3, 1941, and was discharged as recovered.

CASE 3

On November 10, 1940, M. C. H., age 41, experienced pain in the calf of her right leg. The pain at first was intermittent, and she continued to work for two days. On the third day, the leg became swollen and tender. Examination revealed a swollen, shiny right leg with exquisite tenderness over the femoral vein, and a temperature of 100°. Sulfathiazole, one Gram every four hours, was started.

On November 14, swelling with pain appeared in the left leg. Intravenous heparin was instituted. Blood cultures were sterile. The fever continued for 18 days, after which the temperature, except for minor fluctuations, remained normal, and heparin and sulfathiazole were discontinued. Swelling had entirely disappeared from the right leg, but the left leg remained swollen. The patient made a complete recovery, except for some residual swelling of the extremities, for which she wears elastic stockings.

COMMENT

It appears possible that the rate of venous flow may be important in many cases of thrombosis, but in other instances disturbance of the clotting mechanism of the blood, local changes in the walls of certain veins or a combination of these conditions, may be the predisposing factor in the formation of a thrombosis.

Heparin, although apparently effective in the prevention of embolism, probably will be of limited usefulness for the present because of its expense and method of administration. If future developments will permit oral administration, it might become of great value as a routine prophylactic agent. Our use of heparin, both as a prophylactic and therapeutic agent, has yielded gratifying results.

POLIOMYELITIS IN NEW JERSEY

By J. LYNN MAHAFFEY, M.D., Haddonfield, N. J.
Director of Health, State of New Jersey

Acute poliomyelitis has again been prevalent in New Jersey during the present year. Up to November first, reports of 319 cases were received at the office of the State Department of Health. More than the proportionate number of cases occurred in the northeastern section of the state. A pandemic of this disease occurred in 1916 and although its equal has not been approached, since that year a total of 4546 cases have been reported in New Jersey.

Case reports indicate a low incidence during a few years after the 1916 epidemic, followed by a slight increase during the next three years, then a drop followed in turn with a rise in 1927. In 1931 a greater number of cases (975) was reported than in any year since 1916. Beginning in 1933 and continuing to date each alternate year has shown a considerable greater number of reported cases than the intervening year.

No. Reported Cases of Poliomyelitis	Year
234	1933
62	1934
512	1935
28	1936
160	1937
40	1938
230	1939
58	1940
319	(10 months) 1941

If this distribution of reported cases continues, one would expect 1942 to be a relatively low year in New Jersey. Why the prevalence varies so peculiarly presents a subject for much conjecture. We do not have the complete answer.

SEX AND AGE RATIO

Questions are asked about the distribution of cases by sex. Reported cases for the ten complete years 1931-40 were 2660, of which 1555, or 58 per cent, were males.

How were these cases divided by age periods? Of the total, two per cent were in children less than one year old; 37 per cent were

under five years of age; 33 per cent were over five but less than ten years old; and six per cent were in adults above the age of 20. The bracket with the greatest number of reported cases was the group including the first five years of life. The next five-year period also had a high number of cases but, beyond this, the number of reported cases by five-year age groups decreased rapidly. One thousand three hundred and nine, or about half of the cases, were among children of the age group usually in grammar school (5-14 years).

DEATH RATE

What are the fatalities? The actual number of deaths recorded as caused by poliomyelitis is not as high as the public believes. The total recorded deaths from this cause in New Jersey for the 1931-1940 decade was 339.

During the same period measles was recorded as the cause of 421 deaths in New Jersey and whooping cough as the cause of 690 deaths.

SEASONAL FLUCTUATIONS

What of the distribution of cases by seasons of the year, or by months? While cases are reported every month, the three months of August, September and October are the high-rate periods. In the following table the numeral after each month indicates the average number of cases of poliomyelitis reported during that month from January 1, 1931, to December 31, 1940.

January	2	August	77
February	2	September	107
March	1	October	43
April	2	November	13
May	2	December	4
June	3		
July	11	Average Year	267

Assuming a lapse of several days between onset of illness and date of report, it appears that most infections resulting in reported cases occur in mid-summer (July and August).

GEOGRAPHIC DISTRIBUTION

How are cases distributed by areas or counties? Cases are reported from all counties, urban and rural.

While improved highways and general use of automobiles and common carriers result in greater intermingling of population, there still remains in New Jersey two fairly distinct trends in population. For shopping, business and amusements, the major trend in population movement north of Mercer County is toward New York and the metropolitan section of northeastern New Jersey; south of Mercer County, the general trend in population movement is toward Philadelphia and the concentration of population in the Camden section of New Jersey. Mercer and Monmouth Counties divide this general trend; the probable trend in Mercer is more south than north, while the reverse is probably true in Monmouth.

This division of the state would place eleven counties with over 77 per cent of the 1940 census in the northern section, as compared with nine counties (with 22 per cent of the population) in the southern section. Comparing the distribution of reported cases of poliomyelitis by years in these two roughly outlined areas of the state, we find that during most of the years of increased prevalence, the division of cases was not equal per unit of population in these two areas.

In 1931, cases in the northern area were relatively high; in 1932, cases were relatively high in the southern section; again in 1933, the number of cases in the northern section was proportionately high, while in 1934 the southern section relatively suffered most. The number of reported cases in 1935 again increased out of proportion in the northern area.

In years of the lowest incidence (1936, 1938 and 1940), the number of reported cases was divided between the north and south areas in proportion to the population.

The years 1937 and 1939, also, showed a fairly equal distribution of cases as between the north and south sections; however, 1941 has again shown a proportionately high incidence in the northern counties. Possibly this

distribution of cases geographically is merely a coincidence; or it may indicate a wide spread of virus from person to person, resulting in the infection of large numbers of persons through human contact, but which in only a few persons cause illness reaching the stage of paralysis and definite recognition of the dis-



Distribution of reported poliomyelitis cases by counties for first ten months of 1941.

ease. The map clearly indicates the concentration of cases in the northeastern corner of the state. Note that the five counties of Union, Essex, Passaic, Bergen and Hudson accounted for 269 of the 350 cases (that is about 76 per cent of all cases of poliomyelitis), whereas these counties contain only 62 per cent of the population.

MALARIAL DISEASE UNCOVERED BY AUTO-HEMO-FEVER THERAPY AFTER THIRTY-FIVE YEARS

By THOMAS P. PROUT, M.D., Medical Director of Fair Oaks, Summit, N. J., and
CAMELLA A. LOŠADA, M.D., Summit, N. J.

The use of diathermy in the rheumatoid states is not new; but more recently we have been using the diathermy pack with auto hemo-therapy. The success of this treatment in rheumatoid states and particularly its outstanding success in a case in which long-standing malarial infection was a prime factor, is the chief reason for making this report. In this case the painful symptoms referred especially to the spine and, to a lesser degree, to the joints of the lower extremities.

The patient, now a woman of fifty-three, had lived from the age of twelve to eighteen on Long Island. Every spring she suffered an attack of chills and fever. There would be minor daily recurrences of the attacks as the summer progressed. She would be fairly comfortable toward the end of the summer only to repeat over again the same series of symptoms the following spring. At eighteen, she moved to an elevated section of New York City, which was free from mosquitoes, and the active manifestations of malarial disease ceased. At the age of twenty-six, she began having periodic attacks of headache and joint pains, especially in the back. These attacks recurred periodically. By the age of fifty the back pains had become intense and she had considerable difficulty moving about. She suffered especially severe pain in changing her position in bed. Other symptoms included difficulty in sleeping and marked exhaustion. During these periods it would be very difficult for her to compass the usual round of every-day life.

In October, 1940, we began treatment with diathermy plus auto hemo-therapy. Placed in a pack, the heat of which was furnished by short-wave diathermy, the body temperature was raised to 101.5 degrees; the current was then turned off and she remained in the pack until her temperature subsided to normal. This usually required three to four hours. The procedure was repeated three times a week. She

began almost immediately to feel better but there intervened after a time, at about eleven or twelve o'clock at night, a chill followed by fever. As the fever subsided toward early morning she would get several hours of sleep only to have the chill and fever repeated again the following night. This became more pronounced with the continuation of the treatment until there was nightly recurrence of the chill and fever with intense perspiration.

The blood was examined for parasites one day at 5 p.m. The chill was expected at 10 p.m. The malarial organism was found in the blood. There was no splenic enlargement. She was given two grains of quinine sulphate, at nine, ten and eleven that night and slept uninterruptedly. This was repeated for several nights for about ten days; there was no recurrence of symptoms. To date (seven months later) there has been no recurrence of the chill and the patient feels perfectly well. Spine and joint symptoms have entirely disappeared. She states that she is feeling perfectly well for the first time in fifteen years.

COMMENT

We have had no other experience like this but it might be that with further application of this principle we may see other patients who have spent their youths in malarial sections which they left without symptoms only later to experience the development of a rheumatoid or some similar state with the decline of the vital forces accompanying the menopause.

This method of treatment is of some significance. It can evidently bring a latent infective process into evidence. An infection that can lie dormant in the system for a generation stirs the imagination. Means for making such an infective process evident have not heretofore been possible. In this instance, an infective agent lay dormant in the system for at least thirty-five years with no manifestation of its

presence other than the marked invalidism and rheumatoid state. Treated as such by this method it blossomed out into the thing that it really was: malaria. The parasite was found, the specific remedy applied, the final cure achieved.

It would seem that cases of a similar character might show themselves from time to time during the next twenty-five years at least. When we contemplate the devastating influence of malaria on the general health of humanity, we come also to appreciate the fact that the work done toward the elimination of malarial disease in general has played no small rôle in the prolongation of human life.

In the presence of a case like this, the question is raised as to whether a person who has been infected with malarial disease can fully depend upon quinine therapy for its full and final elimination.

The technique of treatment, as outlined by Dr. William K. Ishmael, of Oklahoma City, is as follows:

(1) Ten cubic centimeters of blood are withdrawn from patient's vein and injected immediately into hip muscles.

(2) Ten grains of sodium chloride are given with water.

(3) Patient is placed on a fever bed prepared as follows:

Foundation—

Wooden table covered with cotton mattress.

Cable of short-wave diathermy apparatus of inductance cable type placed on mattress.

Cotton pad covered with bed sheet over cable.

Dry Unit—

Blanket and sheet folded fanwise to be used after patient has reached desired temperature and returned to 99 F.

Wet Unit—

Woolen blanket.

Cotton sheet.

Turkish toweling sheet.

Patient in long-sleeved cotton gown is wrapped in wet unit and a temperature of 101.5 F. induced and maintained for one hour after which patient is allowed to cool and when a temperature of 99 F. is reached the wet unit is removed and patient remains in dry unit until temperature returns to normal.

19 Prospect Street

FEVER THERAPY IN ARTHRITIS

Typhoid vaccine fever therapy for febrile cases of arthritis is recommended by William J. Yott, M.D., in The Journal of the Michigan State Medical Society, who warns that it should never be administered in the presence of liver damage. The other contraindications are cardiac disease, elderly patients and tuberculosis. A case is cited in which cincofen had been

administered previous to the typhoid intravenous injection with the resultant death of the patient. Autopsy showed acute yellow atrophy of the liver with intense jaundice and gastrointestinal hemorrhage. The author believes that the typhoid vaccine administered after cincofen liver damage resulted in the patient's death.

STATISTICS ON PUERPERAL HEMORRHAGE AS A CAUSE OF MATERNAL MORTALITY IN NEW JERSEY

MATERNAL WELFARE ARTICLE NUMBER SIXTY-FIVE

By ARTHUR W. BINGHAM, M.D., East Orange, N. J.

Chairman, Committee on Maternal Welfare of The Medical Society of New Jersey; and
Chief Advisory Obstetrician, Bureau of Maternal and Child Health,
State Department of Health.

This is the fifth article on New Jersey Maternal Mortality Statistics for 1940.

The 1940 maternal mortality rate in New Jersey for puerperal hemorrhage is three per 10,000 live births. As indicated on the graph (Fig. 18), there has been considerable improvement since 1931 when the Committee on Maternal Welfare was first appointed. The rate then was 7.4 per 10,000 live births.

In 1940, nine of the ten rural counties and four of the eleven urban counties had no deaths from puerperal hemorrhage. In the rural counties there were 6,998 live births with two deaths from hemorrhage, giving a rate of 2.8 per 10,000. There were 51,620 live births in the urban counties with 16 deaths making a rate of three per 10,000. However, two of the urban county deaths were in rural districts in those counties so the advantage is not all rural. Six counties (25,703 live births) had higher mortality rates for puerperal hemorrhage (average rate—6.2) than the State as a whole.

Of the 18 deaths, 16 were in white and two in colored patients. Six were primigravida, 10 multigravida, and two histories did not state. Ages ranged from 24 to 41, with the average being 31 years. Period of gestation varied from three cases at seven months to 11 cases at term. Length of time from delivery to death varied from one hour to 17 days. Eleven patients died within six hours of delivery, and two died undelivered.

Of the 16 cases delivered there were eight live births, seven stillbirths, and one macerated foetus.

UNDELIVERED CASES (2)

Case 104.—Gestation 7 months. Age 29 years. No prenatal care. Hemorrhage from placenta previa. Found dead in bed.

Case 152.—Gestation 8 months. Age 38 years. Placenta previa. Induction of labor with pituitrin 3 min. q. 1 h. for 4 doses and quinine grs. x and castor oil. Patient went into active labor for a few hours. Condition suddenly became grave and patient died. According to autopsy, cause of death was shock and hemorrhage. Patient had one prenatal visit before admission to hospital.

PLACENTA PREVIA (4)

Two undelivered cases just described, Nos. 104 and 152.

Case 10.—Grav 2 para i. Gestation 8 months. Age 34 years. Marginal placenta previa. Prenatal care beginning sixth month. Hemorrhage before delivery. Version. Breech. Gas and ether anesthesia. Stillbirth. Patient died one hour post partum.

Case 16.—Grav xii, para vii. Gestation 9 months. Two months prenatal care. Chronic nephritis. Hemorrhage before and after delivery. Cesarean. Developed anuria following transfusion 14 days after delivery. Died 3 days later. Macerated foetus. Ward free case. Urban resident.

PREMATURE SEPARATION OF PLACENTA (1)

Case 66.—Primigravida. Gestation 8 months. Prenatal care since second month. Not toxic. Labor 20 hours. Sudden profuse hemorrhage 8 hours before delivery. Low forceps delivery. Stillbirth. Patient died 2½ hours post partum.

PUERPERAL HEMORRHAGE

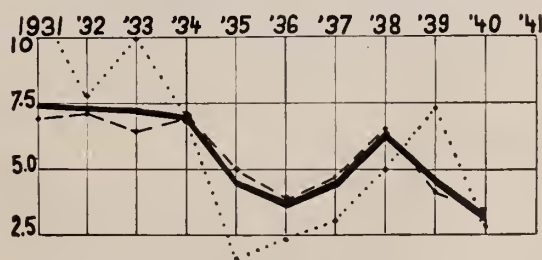


FIGURE 18

POST PARTUM HEMORRHAGE (13)

Case 22.—Grav ii, para i. Gestation 9 months. Six months' prenatal care. Short labor. Normal delivery. Moderate hemorrhage following delivery, did not seem severe. Live baby. Patient died 2½ hours p. p.

Case 21.—Grav i, para 0. Gestation 8½ months. Prenatal care since third month. Normal delivery. Laceration repaired. Live baby. Moderate hemorrhage. Gas anesthesia. Patient died 4 hours p. p.

Case 145.—Grav i, para 0. Age 25 years. Careful prenatal care. Cesarean because of a contracted pelvis, confirmed by x-ray. Low flap operation. Vaginal hemorrhage before patient left operating table. Vagina packed. Died while being transfused. Live baby.

Case 148.—Grav iv, para iii. Gestation 9 months. Prenatal care since fifth month. Previous pregnancies and labors normal. Patient found at home in labor and in shock. Sent to hospital. Delivered of stillbirth in 15 minutes. Placenta delivered intact followed by marked hemorrhage. Promptly died. Urban resident. Ward pay case.

Case 159.—Grav iii, para ii. Gestation 7 months. Had tried repeatedly to bring on an abortion by medication. Profuse hemorrhage with onset of labor at home. Spontaneous delivery followed by placenta and considerable hemorrhage. Medication given. A few hours later uterus softened and there was considerable hemorrhage. Uterus was packed and she received more medication, with glucose intravenously; then a transfusion. Died 5 hours p. p. Baby weighed 3½ bs. and lived 9 hours. Rural resident in urban county. Ward pay patient.

Case 165.—Patient delivered by midwife at home. Normal delivery. Adherent placenta. The physician, unable to extract the placenta, sent her to hospital but she died on the way 1½ hours later.

Case 167.—Grav i, para 0. Gestation 9 months. Prenatal care 6 months. Private patient.

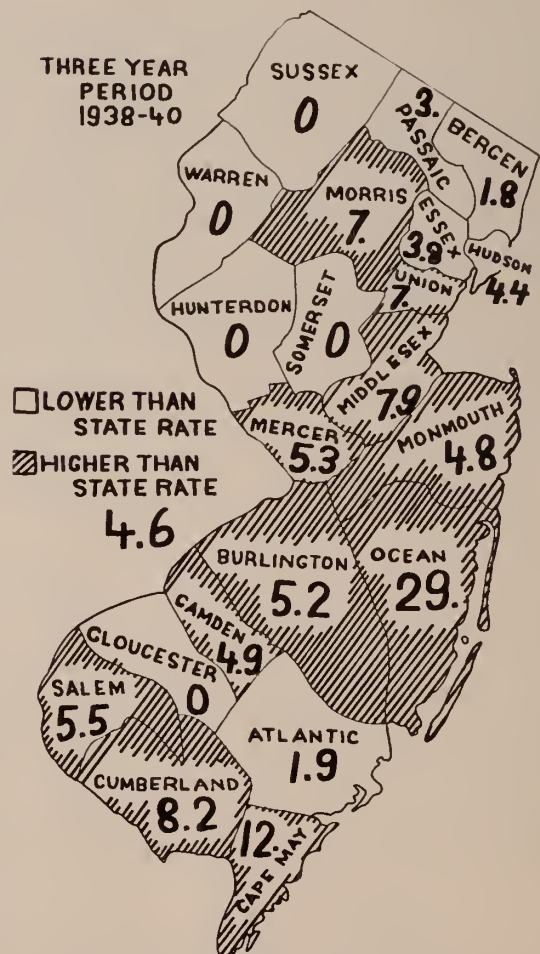
5:30 a. m.—Membranes ruptured.
7:30 a. m.—Irregular pains.
3:30 p. m.—Some show and some bulging.
4:58 p. m.—One cc. pituitrin given.
6:15 p. m.—Patient returned to room undelivered. Given nembutal Gr. iss.
7:00 p. m.—Caput visible.
8:00 p. m.—More progress.
10:30 p. m.—Delivered by consultant with low forceps. Episiotomy. Placenta retained. Adrenalin given to relax cervix. Delivered in pieces.
11:35 p. m.—Pituitrin 1 cc. for moderate bleeding.
12:00 p. m.—Pulse imperceptible. Pituitrin 1 cc. given. Vagina packed.
12:20 a. m.—Vagina repacked.
12:30 a. m.—Morphine gr. ¼, atropine gr. 1/150 given.
2:35 a. m.—Pituitrin, 1 ampoule.
3:28 a. m.—Patient died. Baby lived.

Case 29.—Grav i, para 0. Gestation 7 months. Prenatal care from fourth month. Therapeutic abortion advised on account of hypertension. Patient refused. Labor started spontaneously at 7 months. Patient was very toxic. B. P. 180/130. Delivered

spontaneously. Following delivery of placenta she had a severe hemorrhage. Uterus failed to contract. The uterus was kneaded and pituitrin given, as well as glucose intravenously. She then had repeated hemorrhage and died 9 hours following delivery while being transfused. Baby a stillbirth. Private patient.

Case 89.—Grav vi, para v. Gestation 9 months. One prenatal visit in eighth month. Instructed to return in a week. Hb 60 per cent, B. P. 120/80. Given iron and liver. Did not return. Not in habit of sending for physician in time for delivery. Baby delivered spontaneously (live) before arrival of physician. Placenta expressed. Ergot given. Next day, fundus a little high, binder tightened. During night, patient expelled a large clot and began to bleed. Physician not notified. On afternoon of next day found patient pulseless. Gave intravenous saline and a transfusion but patient died 15 minutes later. Home case, rural county.

PUERPERAL HEMORRHAGE



RATES ARE PER 10,000 LIVE BIRTHS

FIGURE 8

Case 93.—Grav ii, para i. Gestation 9 months. Prenatal care beginning second month. Normal delivery, live baby. Fundus relaxed. Continuous oozing. Uterine packing. Two transfusions. Bleeding continued. Died 6 hours following delivery. Urban resident, private case.

Case 129.—Grav xi, para x. Gestation 9 months. Prenatal care every 2 weeks for 3 months. Pituitrin 1 cc. Normal delivery. Bleeding with adherent placenta. Sent to hospital and died 5 minutes after arriving. Autopsy showed adherent placenta. Stillbirth.

Case 59.—Grav i, para 0. Gestation 9 months. Prenatal care 7 months. Patient had slight spotting of blood at 2 months and off and on until delivery. In mild labor for 4 days. Difficult delivery, breech. Second degree laceration repaired. Had some fever on and off, and on eighth day p. p. passed some large clots. Ergot and pituitrin given followed by transfusion. More clots were passed and while preparing to pack uterus patient died. Uterus found to be full of blood clots. Stillbirth. Private patient.

Case 13.—Grav ix, para viii. Gestation 9 months. Prenatal care 6 months. Home delivery. Baby stillborn after a number of hypodermic injections had been given. Attending physician died shortly after so history is scant. Immediately after delivery physician left, leaving delivery of placenta to a neighbor. Patient complained of increasing dyspnoea and died 2 hours later, probably from hemorrhage.

CESAREAN SECTION (2)

Case 16.—Described under Placenta Previa.

Case 145.—Described under Post Partum Hemorrhage.

PLACE OF DELIVERY

Of the 18 puerperal hemorrhage deaths, 12 patients were delivered in hospitals and died. One home delivery was attended by physician and died. One home delivery was unattended. One was found dead in bed at home, undelivered. One died in hospital undelivered. One home-delivered patient was sent to hospital as emergency and died there. One patient was delivered by midwife and sent to hospital, where she died.

COMMENT

A study of these deaths from puerperal hemorrhage shows that several of them might have been prevented. Lack of coöperation of the patient was a factor in a few cases.

Every physician taking obstetric cases should formulate in his mind some recognized treatment for the several types of hemorrhage so that when he meets with a case no time will be lost in giving proper treatment. Hospitals should keep printed rules of procedures available for the aid of interns in emergency before the attending obstetrician can be reached. This is something which can easily be done and it is recommended that it be carried out by every obstetrician and in every hospital. Correct treatment, promptly carried out, saves lives.

144 Harrison Street

A LESSON FROM A DEATH CERTIFICATE

NUMBER THIRTY-SIX

Patient, a primigravida, had moderate analgesia. Normal delivery.

Pituitrin given following birth of baby. Placenta retained. Very little bleeding. After one hour patient was put to bed and the physician left the hospital.

Two hours later there was considerable hemorrhage. Physician was notified. By the time he arrived considerable blood had been lost and

he decided on a manual extraction. During this procedure the patient suddenly died.

Some of us believe it is unsafe to leave a patient with a retained placenta; that it is better to do a manual extraction before the hemorrhage takes place and then pack the uterus with idioform gauze.

A. W. BINGHAM, M.D.

DOCTORS' DAY IN ELIZABETH

THE CLINICAL CONFERENCE IN RETROSPECT

The best-attended Fall Clinical Conference in the history of The Medical Society of New Jersey held the stage in Elizabeth last week. Five hundred physicians converged on the Union County metropolis; more than a hundred crowded into the lecture hall of the Elizabeth General Hospital to attend a carcinoma demonstration prepared by DR. ARTURO CASSILLI (Pathologist to the hospital) and DR. W. O. WUESTER (Director of the Green Memorial Clinic). At the same time, seven teams of physicians visited as many industrial plants in the Northern New Jersey area to inspect their medical departments and to take part in discussions of industrial medicine. In the afternoon, more than 250 members witnessed a well-rounded schedule of scientific moving pictures, while another group heard the papers presented at the scientific section meetings. Climax of Doctors' Day was a banquet, with Johannes Steel the magnet that drew 400 physicians to hear his vigorous talk on world conditions. Toastmaster was DR. EDWARD G. BOURNS of Westfield, who lubricated the synapses between speakers by bubbling comments, appropriate anecdotes and highly informal introductory remarks.

DR. MORRIS

Dr. Watson B. Morris, Junior Fellow of The Medical Society of New Jersey and General Chairman of the Conference Committee, outlined Union County's rôle in the formulation of the program. He explained that the scheduling of seminars at industrial plants was part of Dr. Lewis' thought that National Defense should be the keystone of the Conference. Since these plants had important defense functions, the study of their medical problems was relevant to this general theme. Dr. Morris praised Dr. Falconer-Slater, Executive Officer of the Union County Medical Society, and Mrs. Rogers, her secretary, for their efficient behind-the-scenes work in making the Conference a success.

DR. ARMSTRONG

Dr. Lorrimer Armstrong, President of the Union County Medical Society, welcomed the members on behalf of the host county, paid tribute to the Woman's Auxiliary for their work as guides and registrars, and named as persons who had borne chief responsibility for shaping the program: Dr. J. M. Carlisle, Dr. George Seymour, Dr. Watson B. Morris and Dr. Kathryn Falconer-Slater. He expressed gratification at the large and enthusiastic at-

tendance, taking it as a symbol of the success of the efforts of the committee.

DR. HYDE

The next speaker was Dr. Henry van Zile Hyde, Medical Director of the Second Defense Region of the Office of Civilian Defense. Dr. Hyde's talk (in abstract) follows:

Facing the possibility of total war, we have an urgent need for making and implementing plans for the protection of ourselves and our neighbors. These plans presuppose the occurrence of casualties throughout the strategic state of New Jersey. Under such circumstances, it is the doctor who must do the life-saving job, amid confusion and under pressure. Each doctor in New Jersey is thus part of an emergency civilian medical service plan. The Chairman of the Society's Committee on Medical Preparedness, Dr. Charles Schlichter, has been named Chief of Emergency Medical Services for New Jersey, charged with the job of organizing the doctors, nurses, dentists, pharmacists, etc., in such a way that New Jersey casualties will be tended swiftly and properly. Dr. Schlichter has accepted this onerous task without compensation. He will enjoy the help of Dr. Norman M. Scott, who will be his Associate and will nominate deputy chiefs to be attached to branch offices of the State Defense Council. These nominations will be made in consultation with county medical societies. The deputy chiefs will coördinate the work of the local and municipal chiefs of medical service, now being appointed by local defense councils.

The organization of emergency medical services will revolve around hospitals. Each hospital will be asked to equip several units of doctors, nurses, and aides to be available 24 hours a day to set up casualty stations. Everyone will be asked to assist promotion of the voluntary nurses' aide training programs.

The United States Office of Civilian Defense looks to the doctors for continued leadership in the development of emergency medical service. I urge your full and hearty coöperation. The administrators of these services have a heavy load to carry; the way is hard and rocky and the trail poorly marked; they hope, with all of us, that when they deliver the goods, they won't be needed!

DR. LEWIS

Dr. Thomas K. Lewis, President of The Medical Society of New Jersey, expressed the Society's appreciation of the work of the host organization, and announced that this was the best-attended Clinical Conference in the Society's history. He applauded the presence of doctors' wives at the banquet, hailing this as a commendable innovation. The Clinical Conference itself, Dr. Lewis pointed out, was a token of the Society's major interest in scientific medicine, which must not be forgotten in our growing concern with the economic and administrative problems of the profession. He tossed Camden County's hat into the ring as

a candidate for the position of host to the Fifth Annual Fall Clinical Conference next year.

JOHANNES STEEL

A rousing reception welcomed Johannes Steel, the distinguished commentator of the Mutual Broadcasting System, who pulled no punches in his "Realistic Appraisal of World Conditions". Mr. Steel's talk (in abstract) follows:

The war will last from five to ten years and will actively involve the United States. The enormous productive capacity of Europe's industries will keep the German Army in service until it is defeated in the field. Furthermore, this war is generating hatreds so bitter and so scarring that these attitudes may last for centuries. Memories of blasted villages, murdered civilians, and the horrors of the concentration camp will hover over the peace table.

Greatest story of the war is the morale of the women of England. Had the women wept, the war would have been lost. Another major asset of the Allies is the coöperative attitude of capital and labor in Britain. A third is the truly magnificent resistance of the Russian Army. In 1918, Russia was a semifederal, non-industrial state. In two decades, the Soviets created an industry and a morale that made the Red Army capable of standing up to the most powerfully mechanized army the world has ever seen.

The rôle of Japan has been to immobilize the Pacific fleets of Britain and the U. S. A. If the Japanese seize the Malay Peninsula they can shut off the supply of tin and rubber which this country needs.

The United States has a stake in the war. It takes no longer to fly from Dakar to Brazil than it does to fly from Omaha to New York. The question is: do we go to war when Hitler wants us to or are we going to pick the time ourselves? If we go today, we have allies. Tomorrow we may be alone. And God help us, if we go alone!

INDUSTRIES

The following industrial plants played host to members who took part in seminars on industrial medicine: (1) Calco Chemical at Bound Brook, (2) General Aniline at Linden, (3) American Cyanamide at Linden, (4) Merck Co. at Rahway, (5) Standard Oil at Elizabeth, (6) U. S. Metals at Carteret, (7) Western Electric at Kearny.

TREATMENT OF CANCER

At the Elizabeth General Hospital, DR. CASILLI and DR. WUESTER presented fifteen cases of cancer and discussed treatment indications and results. Many of the patients were present in person. Lantern slides illustrated the appearance of the lesions and the operative techniques. The speakers were introduced by DR. MILTON SHANGLE, President of the hospital's Medical Staff. Dr. Casilli stressed the importance of the biopsy and described the aspiration method widely used at the Green Memorial Clinic. He outlined clinical and histologic scales for the grading of malignancy.

Dr. Wuester presented the case records, described the clinical findings, explained the treatment procedures, and demonstrated the patients.

SCIENTIFIC SECTIONS

Breast milk was hailed as a life-saver for premature babies by DR. ALBERT S. HARDEN, JR., who detailed the operation of the breast milk station at the Babies' Hospital. The method of managing a pregnancy complicated by ovarian cyst was outlined by DR. ROBERT A. MACKENZIE, who presented four illustrative cases. The procedure for measuring blood-flow speed was described by DR. EDWARD C. KLEIN, JR., who showed how differences between affections of the right and left sides of the heart caused alterations in arm-to-lung and arm-to-tongue circulation time. DR. H. J. PERLBERG urged wider use of x-ray in pregnancy, pointing out how roentgenograms helped in the diagnosis of twins, the localization of fetal position and the evaluation of pelvic dimensions. The importance of treating soft-tissue injury in fractures was stressed by DR. ELMER P. WEIGEL, who reviewed modern methods of managing compound fractures. DR. HENRY C. BARKHORN characterized destruction of the tonsils by diathermy as a "half-way measure", and described the eversion-and-snare technique of tonsillectomy. DR. HYMAN I. GOLDSTEIN related the history of our knowledge of carcinoma and ulcer of the stomach during the Middle Ages.

MOVING PICTURES

The Medical Film Guild supplied six moving picture films covering the following subjects: (1) Peritoneoscopy, (2) Sinusitis, (3) the use of coramine, (4) Treatment of ulcer with mecholyl by iontophoresis, (5) Otoscopy and (6) Modern methods of blood transfusion.

The Davis and Geck Company supplied the following eight films: (1) Diseases of the Breast, (2) Suture of the Recurrent Laryngeal Nerves, (3) Hernioplasty, (4) Vaginal Repair, (5) Skin Grafts, (6) Surgical Treatment of Varicose Veins, (7) Joint Debridement and (8) Resection of the Colon.

IN CONCLUSION

The Conference Committee arranged extraordinary weather: it was the warmest and pleasantest December 3 since the turn of the century. There was so much doing and so much to see that guests could hardly realize that all this took place in a single day. The machinery of the Conference whirled smoothly. The Union County Medical Society proved itself a strong, well-organized group that had something worth showing. Verily, in Union there was strength.

LOCATIONS FOR PHYSICIANS

A serious need for additional physicians exists in many of the vital defense areas. These shortages have arisen because of the great increases in civilian population which have occurred during the year. The needs exist in a large number of states in communities varying in size from small villages to large cities.

The demand for medical care is already so urgent that it should be relatively easy, in many places, to establish practice at once. Furthermore the coming of winter will result in overtaxing the medical personnel in many other localities where at present the physicians are very near the limit of their capacities.

In most of these defense areas there are Defense Housing Projects in which office space or living accommodations, or both, may be se-

cured. Surveys in progress have already revealed a number of areas which need physicians and as additional areas are surveyed, other important locations will undoubtedly be found.

The United States Public Health Service, in coöperation with the Division of Defense Housing, of the Federal Works Agency, which supervises these projects, is interested in acquainting physicians with the needs of these communities. If you are interested in securing more specific information about localities for the establishment of practice, please communicate with me.

THOMAS PARRAN, M.D., Surgeon General,
United States Public Health Service,
Washington, D. C.

IMPROVEMENT IN SCHOOL MEDICAL SERVICE

IV

From the American Academy of Pediatrics

Our last report pointed out some common unsound policies and procedures of school health programs and recommended principles for the improvement of school medical service. New evidence that is accumulating indicates trends that are definitely encouraging and in accord with the recommendations of your Committee. The following are some of the tendencies noted in school health literature and to some extent in actual practice:

1. More emphasis is placed upon medical guidance and consultation than upon medical inspection or annual health examinations.

2. The limitations of a school health service are being recognized and the personal physician and other community medical facilities are being regarded as essential parts of health service to the child.

3. More attention is being given to medical history, to teacher observations and to the quality of medical judgment which considers the whole child rather than adherence to frequent examinations and the stressing of the physical defects discovered.

4. Examinations by private physicians and dentists are being increased in some communities and fewer school authorities are assuming that they can meet all the needs for health supervision of the school child.

5. Screening devices such as observations of the teacher, sickness absence records, dental service records, Snellen and audiometer

testing and teacher-nurse conferences are used more and more for economical case finding and there is less preoccupation with the routine medical examinations.

6. Policies are being defined with long range planning by educational, public health and medical leadership and in some places there is evidence that "mutual appreciation of the other person's problems and clear definition of what each shall contribute to their solution" is replacing mere school or health authority.

7. A realization of the responsibility of parents for caring for their children seems to be making some gains over previous trends to provide all health supervision through the schools.

8. The objectives for the physician and nurse in the schools is more and more being defined in terms of health education and there is a growing tendency to recognize that the purpose of the school health service is "to present information, to motivate to action and to guide that action". Education for individual responsibility is more often mentioned than formerly and there is less heard about complete and thorough health supervision through the schools.

These trends in thinking and the few actual changes in activity in school health programs offer new opportunities for medical leadership in this branch of public health. They are consistent with the principles of the American Medical Association and the best tradition of medicine.

MALPRACTICE INSURANCE OF PHYSICIANS SERVING IN THE ARMY AND NAVY AND ON SELECTIVE SERVICE BOARDS

The Medical Defense and Insurance Committee wish to call the attention of Society members to the editorial in the Journal of the American Medical Association of September 13, 1941, p. 936 regarding "malpractice actions against Army Medical Officers and examining physicians for local selective service boards". This article has prompted inquiries from many physicians now in (or about to enter) government service in various capacities as to what their status would be under their professional liability contracts. Relative to this article the following information gives the views and decision of the United States Fidelity & Guaranty Insurance Company of Baltimore, official carrier of malpractice insurance for Society members:

The Company is willing to write, for any doctor of the Society, otherwise meeting their underwriting requirements, a physician's liability policy or continue one for an insured who enters the service.

It does not appear that a doctor has much liability for malpractice in treating soldiers or sailors; nor for actions arising out of his connection as examining physician in a draft board, particularly as the Government will provide defense. Hence, the company does not think that it should recommend insurance for practitioners under either circumstances except what seems to be a possible additional hazard, which is that of the doctors entering the service who leave their civilian practice in the hands of another doctor. In such a case, the first doctor has a contingent liability and may still need professional liability insurance

for claims arising out of his civilian practice while he was away.

In writing or continuing insurance in either event, the company can offer to do so at one-half of the premium which would be charged for the doctor insured while he is active under ordinary circumstances in civilian practice.

The reduction of the premium would be given by rider which would also explain that from that date so long as the company is willing to continue at the reduced premium, the claims or suits covered must arise (1) from treatment of soldiers or sailors while in the military or naval service of the United States as a commissioned officer of the Medical Corps of the Army or Navy, or, (2) while he is such a commissioned officer, arising from his former patients due to treatment by his locum-tenens, or (3) arising out of his services as a physician for any draft board.

However, the company does not think that the last contingency will affect a reduction of premium because doctors serving as draft board physicians still maintain their regular practices.

While the practitioner is serving as examining physician or dentist for a draft board he is still in civilian life. His policy covers him for any of his professional acts or omissions while working as a member of the draft board just as it does for his regular civilian practice and no endorsement is needed under these conditions.

CHRISTOPHER C. BELING,
Chairman of the Medical Defense
and Insurance Committee.

CIVILIAN DEFENSE

Dr. George Baehr, Chief Medical Officer of the Office of Civilian Defense, announces the appointment of a special sub-committee to prepare recommendations on hospital procedure in the event of belligerent action.

Chairman of this committee is Dr. R. C. Buerki, Director of Hospitals of the University of Pennsylvania, and the membership includes Dr. W. C. Rappleye, Commissioner of Hospitals in New York City, and Dr. Joseph Turner, Director of the New York Mount Sinai Hospital, as well as several other distinguished hospital executives.

Dr. Baehr also announces the appointment of a Medical Director for each Defense Region. New Jersey lies in the Second Defense Region, and the Medical Director is Dr. H. Van Zile Hyde, 111 Eighth Avenue, New York City. Within the regions, each state will also have a Medical Director. The Medical Director for New Jersey is Dr. Charles A. Schlichter, and his Associate is Dr. Norman M. Scott. The Regional Directors have been commissioned as Senior Surgeons in the United States Public Health Service.

THE BROADER VIEWPOINT

By LEROY A. WILKES, M.D., Executive Officer

Physicians in private practice can easily make statements regarding the physical status or disease incidence in the community which, though it appears to them as a logical deduction, may be the exact opposite of the truth. For instance, in my own experience, in a city of 160,000 a general practitioner who had just visited a family in which there were six cases of measles met the Superintendent of Schools, who by way of conversation asked: "How are health conditions in the city?" The physician, disturbed at seeing six cases of measles in one family, said, honestly but untruthfully, "The city is full of measles."

The Superintendent of Schools, on reaching his office was informed by his secretary that six cases of measles had been reported in a certain school. This was unusual at that time of year, and when a newspaper reporter later in the day asked about health conditions in the schools the Superintendent informed him that "the schools are full of measles".

Without inquiry to the proper source of official information on community health (namely the Health Department), the newspaper published, in its early edition, the statement that there was an epidemic of measles in the town. The Health Director immediately called the editor and informed him that never in eighteen years had the incidence of measles in this city been at a lower point, and that the statements were entirely contrary to the fact, as established by Health Department records.

While the physician visiting the individual patient is the most reliable source of information regarding those individuals under his clinical observation, the picture of the health status of the community is built upon reports of many family physicians. In this composite picture are many aspects of the control of communicable diseases unfamiliar to the individual physician. Fortunately the modern physician is now acquainting himself with these newer developments in health supervision and protection, in his rôle as a member of his medical society. The M.D., in his clinical observations, describes the individual's illness in terms of symptoms and lesions presented by the patient.

The community health officer is interested in those aspects of disease which lead him especially toward the cause of disease, which in many cases can be removed and through which he can determine how to prevent future attacks. These aspects are epidemiologic studies

described in terms of mass phenomena rather than in terms of the individual's clinical status. The following are some points in these studies which are of primary concern to the Health Officer: geographic spread, the seasonal and other chronologic variations in the appearance and duration of the disease, its incidence by age and sex, and its prevalence in urban as compared with rural areas, and among patients according to economic status.

Between these two types of studies concerning the characteristics of illness, lie certain descriptive items which aid in the understanding and control of various forms of illness. These items, which are of interest to both the physician in private practice and the public health department, include the average duration of symptoms; period of inability to work; portion of this period during which the patient is confined to his bed totally disabled; how many calls the average doctor makes per case on various types of illness; and what types of practitioners—licensed and unlicensed—attend different types of illnesses, in terms of percentage of cases attended by each type. In these descriptive items there are of course certain artificial divisions which involve the economic status of the patient and his ability to afford the full required medical services. Of course, provisions are made for the indigent but these are used according to the economic status, intelligence and initiative of the individual. The economic status of the patient also, in part, determines to a considerable degree how many days of work he can afford to lose and how short his convalescent period must be, regardless of his medical needs. Some patients have a sick leave with pay, provided under the social legislation now in effect. Others are without such benefits and return to work before they are really able.

A study of these subjects is reported in the October 10, 1941, issue of Public Health Reports, volume 56, number 41, obtained from the United States Public Health Service in Washington, D. C. These reports indicate some of the studies now being made and are as yet far from complete, but the gathering and studying of such data will help everybody concerned to appreciate the many health implications of their work, and will contribute to a better understanding of the problem and a more effective protection of the public's health.

EAGLETON'S INDEX

A cumulative index of all important articles in the field of otology, rhinology and intracranial lesions has been prepared by Dr. Wells P. Eagleton. This unique compendium of medical progress covers eight significant, selected years between 1925 and 1940, and, according to the title page inscription, is

"published for gratuitous distribution to American and British otologists in the interests of Anglo-American unity, and to commemorate the enactment of the Lend and Lease Law—a new *Magna Carta* of democracy's international coöperation."

The volume is divided into four sections. First is a topical index of articles arranged alphabetically by "the chief thought" of each paper. In this section are such headings as Diphtheria Bacillus, Dysphagia, Nystagnus, etc. Second is an index in which citations are classified according to subject matter—as for example, Cerebral Hernia, Hydrocephalus, Sinus Thrombosis, etc. The third division is a listing by authors. The fourth section (constituting more than half the volume) is an appendix containing eight full reprints of Dr. Eagleton's well-known "surveys of recent literature" arranged by years. These "surveys" are compact, critical reviews of the literature assembled by subject.

The dedication to Eagleton's Index reads as follows:

From 1925 and including 1940, I abstracted such of the literature as contained advances in our knowledge of intracranial states in relation to normal or diseased ear, nose and throat conditions. Eagleton's Index is an assembling of all of the articles and of the thoughts or facts emphasized by me in successive abstracts.

My purpose in its gratuitous publication is to make accessible to any sincere worker a compila-

tion of the recent literature on the borderline subjects pertaining to otology or rhinology, and neurology or neurosurgery, a field of surgical activity which has engaged my efforts during the past 25 years. Up to the present, such a compendium of subjects and evaluation of facts have not been presented in their entirety.

Since sending the Index to press on the date of the enactment of the Lease and Lend Law, the pronouncement of the *Atlantic Charter* carried the United States and Great Britain a step further toward that Union of the English-speaking nations in which lies the hope for a continuation of our Christian civilization.

President Roosevelt's subsequent declaration "we Americans have taken our battle stations" presages that out of the united sacrifices and efforts of the freedom-building nations of the world, there will emerge a more Christ-like culture in the future.

With thanksgiving for my country's participation in this struggle for freedom, I rededicate this volume.

WELLS P. EAGLETON.

Newark, N. J., Nov. 17, 1941
(Repeal of Neutrality Law)

Dr. Eagleton, a Fellow and Past-President of The Medical Society of New Jersey, received the Award of Merit of the Society at its Annual Meeting on June 3, 1940. He was also the first recipient of the Edward J. Ill Award, presented by the Academy of Medicine of Northern New Jersey in May, 1939, and in May, 1938, he received the Gold Medal of the Oto-Rhinologic Section of the Kings County Medical Society.

Eagleton's Index is published in two editions. One contains only the index itself, without the abstracts; the other includes the appendix of reprints of Dr. Eagleton's Surveys.

Each format is published in a limited edition of a thousand copies.

NEW JERSEY DEFENSE COUNCIL

The State Defense Council is developing plans to provide for medical services in times of civil or military disaster. The plans, adapted to the needs of New Jersey, will follow the general policies and provisions recommended by the Federal Office of Civilian Defense.

Dr. Charles H. Schlichter of Elizabeth, Chairman of the Medical Preparedness Committee of The Medical Society of New Jersey, has been appointed Chief of Emergency Medical Services. Dr. Norman M. Scott of

Trenton, Secretary of the Committee, has been appointed Associate Chief of Emergency Medical Services. Both will act without compensation.

Temporary offices have been opened in Trenton. Dr. H. Van Zile Hyde, Medical Officer of the Second Corps Area Office of Civilian Defense, will assist in the organization of the program.

Plans call for the appointment of a medical director in each municipality and for the organ-

ization in every hospital of one or more Emergency Medical Field Units. These units will be composed of squads of physicians, nurses, nurses' aides and orderlies. One or more squads from each hospital will be available for duty during each of the twelve-hour periods of the day. Upon receiving a call the squad will proceed to the point designated, arriving with equipment and prepared to set up a casualty station where the injured will receive treatment.

Rescue squads especially trained and

equipped to extricate and transport injured persons from the danger area will be provided. They will carry extra equipment in the form of stretchers, cots and blankets.

From the Casualty Station, after receiving emergency treatment, the injured will be evacuated to their homes or to hospitals whose medical staffs have in the meantime prepared for their reception and definitive care.

For further information, members should write to Dr. Scott in Trenton.

CONFERENCE OF STATE SECRETARIES

The American Medical Association was host, last month, to the Secretaries and Editors of the constituent state medical societies, who met in Chicago on November 14 and 15 to talk over organizational problems. The Medical Society of New Jersey was represented by its Secretary, Dr. Alfred Stahl, and by the Editor, Dr. Henry A. Davidson.

The two morning sessions were devoted to medical preparedness. Colonel McAfee, representing the Surgeon-General, spoke of the Army's present need for medical officers. Dr. Fred W. Rankin, President-Elect of the American Medical Association, discussed the A. M. A.'s rôle in medical officer procurement. Captain Watson Miller, Assistant Administrator of the Federal Security Agency, reviewed the problem of the physician in the United States Civil Service. Major Seeley described the new office for the Procurement of Medical Personnel and explained how it would function. Dr. Irvin Abell, Chairman of the A. M. A.'s Committee on Medical Preparedness, interpreted the relations of the A. M. A. to the new procurement division. Dr. George Baehr, Chief Medical Officer of the Office of Civilian Defense, detailed the techniques that would be used by emergency medical teams responding to disaster situations. The morning session was climaxed by a vigorous, hard-hitting talk by Brigadier-General Lewis Hershey, Director of the Selective-Service System, who frankly discussed the medical problems precipitated by the draft law. General Hershey announced himself as favoring remuneration for civilian draft board medical examiners, discussed the one-examination and two-examination systems, and answered questions on the deferment

status of interns, medical students and residents.

The afternoon session was a symposium on society-sponsored health insurance plans. Michigan, California and New York—among many other states—reported details of their medical service programs. The Society Secretaries freely exchanged ideas on the practical aspects of such projects. It was interesting to note that the Medical Service Administration of New Jersey incorporated the best features of the most effective plans, and had avoided some of the proposals found, in practice, to be cumbersome or unworkable.

The evening meeting was a clinic for editors. Dr. W. N. Johnson, Editor of the North Carolina Medical Journal, pointed out a number of ways in which a state Journal could best serve its Society. Dr. Robert Nye, Editor of the New England Journal of Medicine (the oldest of the state medical journals and the only weekly among them), discussed in detail the way in which his periodical solved many of the technical, editorial and mechanical problems of issuing a journal. Type-size, handling of illustrations, financing, reporting, editorial writing, book-reviewing, evaluating original articles, and other phases of medical journalism were reviewed and analyzed.

This Conference of Secretaries and Editors is an annual project, sponsored by the American Medical Association. Secretaries and Editors from Maine to Hawaii were in attendance at the four sessions, and the intermingling of Society Officers from all parts of the American commonwealth proved an impressive token of the singleness-of-purpose and integration-of-function of Organized Medicine in the United States.

OBITUARIES

DR. CARROLL D. SMITH

Dr. Carroll D. Smith of Paterson, a member of the Passaic County Medical Society and one of the leading proctologists in New Jersey, died on October 28, 1941, after a brief illness. Though only 42 years old at the time of his death, Dr. Smith had already attained high repute in the field of disorders of the lower bowels, and one of the leading scientific moving picture films of proctologic surgery taken by the American Medical Association was filmed with Dr. Smith as the surgeon. Dr. Smith came from Texas in 1921 to accept an internship at Paterson General Hospital, and his adopted county has been his home ever since.



DR. ANTHONY S. MACIEJEWSKI

Dr. Anthony S. Maciejewski, a member of the Essex County Medical Society, died at his home in Newark on November 7, 1941. Dr. Maciejewski was Assistant Police Surgeon of the City of Newark and was on the Staff of St. James Hospital. Born in Poland, he came to this country at the age of seven and was graduated from the Temple University Medical School in 1916. He was commissioned as First Lieutenant in the United States Army Medical Corps in 1917, and in 1918 was promoted to Captain. He had been practicing in Newark since 1920.

DR. JOSEPH WIENER

The Chief Cardiologist of the Monmouth Memorial Hospital and the Fitkin Memorial Hospital, Dr. Joseph Wiener, died September 8 of coronary thrombosis.

Dr. Wiener, who was only forty years old at the time of his death, was a member of the Monmouth County Medical Society. He was graduated in 1925 from the Medical School of the University of Pennsylvania.

SUPPLEMENTARY LIST OF MEMBERS NUMBER EIGHT

to the

OFFICIAL LIST OF MEMBERS, MARCH 15, 1941

The figures in parentheses refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

ACTIVE MEMBERS

Angelo, Joseph A., Fort Knox, Ky. (9)
Barone, Francis A., Camp Lee, Va. (9)
Betcher, Albert M., Fort Dix (9)
Bonomo, Michael J., 587 S. 10th st., Newark (7)
Brignola, G. C., Fort DuPont, Del. (9)
Christian, Henry A., Fort Fay, N. Y. (9)
Coffey, Michael J., 24 W. Market st., Newark (7)
Cupaiuoli, R. A., Navy Base, Iceland (9)
Decker, Frederick H., Frenchtown (10)
DeFusco, G. Thomas, Fort DuPont, Del. (9)
DiBiaso, Cornelius V., 9 W. Park pl., Rutherford (2)
Duffy, Jos. F., 358 Kinderkamack rd., Westwood (2)
Dulany, Theodore L., 170 W. Market st., Newark (7)
Edgerly, Sherburn E., 185 E.P'is'des av., Engl'w'd (2)
Emory, Geo. B., Jr., 1 Franklin pl., Morristown (14)
Fadden, Francis J., Jr., 275 Engle st., Englewood (2)
Fasano, Giovanni, 194 S. 7th st., Newark (7)
Frazee, Wm. H., Jr., Co.H., 119th Med.Reg., Ft.Dix (15)
Friedenthal, Bernard, Aberdeen, N. C. (12)
Friedlander, Kurt F., 413 Lyons av., Newark (7)
Gitterman, David A., 519 Engle st., Englewood (2)
Goldsmith, Alfred S., Marine Base, New River, N.C. (9)
Goldstein, Joseph D., Fort Dix (9)

Grasso, Anthony P., 81 N. 9th st., Newark (7)
Kilts, Winfield S., 966 Garrison av., Teaneck (2)
Kohn, Leo, 301 S. Orange av., South Orange (7)
Kralick, Louise C., 248 Terrace av., Hasb'r kHgs.(2)
Kraut, Arthur M., Fort Dix (9)
Liefeld, Walter L., 127 W. Passaic av., Rutherford (2)
Marshall, Frank A., U.S. AirCorps, M'x'wllFd., Ala (9)
O'Lini, Louis J., 30 W. Market st., Newark (7)
Palazzo, Wm. L., 135 Cornelia st., Boonton (14)
Revere, Seth D., 600 Park av., East Orange (7)
Rosenberg, Albert B., 69 Myrtle av., N. Plainf'd (9)
Simpson, David B., 1st Med. Bn., Ft.Devens, Mass (9)
Smith, Arthur B.R., 41 Tow'r Blvd., N'w London, Conn. (9)
Thompson, Edna R., Main rd., Flanders (14)
Vandersluis, Harold H., 86 S. Main st., Park Ridge (2)
Yontef, Reuben, Fort Jackson, S. C. (9)
Ziccardi, Anthony, Evans Bldg., Maple Shade (3)

ASSOCIATE MEMBERS

Bremer, Kenneth M., 85 S. Harrison st., E. Orange (7)
Dann, Frederick J., 619 Stuyvesant av., Irvington (7)
Murphy, Thos. W., Jr., 58 Old Sh't Hls. rd., Sh'rt Hills (7)
Rowe, Jack M., 27 Park pl., Bloomfield (7)
Van Riper, Wm. D., 314 Engle st., Englewood (2)

● THE BULLETIN BOARD ●

The next regular meeting of the Burlington County Medical Society will be held on *December 11*, at which time Dr. W. Wayne Babcock, Professor of Surgery, Temple University, will speak on "Intestinal Malignancy".

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Dr. Harrison S. Martland, Chief Medical Examiner of Essex County, will present a series of slides showing pathologic specimens of especial interest to physicians on *December 18* at the joint meeting of the Academy of Medicine and the Essex County Medical Society. The meeting will be held at 9:00 p. m., at 91 Lincoln Park, Newark. Dr. William H. Perkins, newly appointed Dean of Jefferson Medical College, Philadelphia, will discuss "Medicine's Inheritance of World War II".

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"The Modern Management of Respiratory Diseases" will be discussed by Dr. Hobart Reimann, Professor of Medicine at the Jefferson Medical College, before the regular meeting of the Gloucester County Medical Society on Thursday, *December 18*, at the Woodbury Country Club.

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The use and misuse of the sulfonamid drugs will be reviewed at the meeting of the Passaic County Medical Society on Thursday evening, *January 8, 1942*, to be held at School No. 13 at the corner of East 22nd Street and 15th Avenue in Paterson. The meeting, which will open at 9:00 P. M., is open to all members of the medical profession.

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"The Practitioner's Surgery" is the challenging title of the feature talk to be given at 9:00 p. m., *January 8, 1942*, by Dr. W. W. Babcock, Professor of Surgery, Temple University, Philadelphia, before the Essex County Medical Society meeting in Newark that night.

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Members of the Morris County Medical Society will hear Dr. W. Goldring, Associate Professor at New York Medical College, discuss nephritis and hypertension at their meeting Thursday evening, *January 15, 1942*, at the State Hospital, Greystone Park, 8:45 p. m.

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The Atlantic County Medical Society will hold its January meeting at the Hotel Tray-

more on Friday, *January 16, 1942*. Dr. Morris Fishbein, Editor of the Journal of the American Medical Association, will be the guest of honor, and all physicians are invited to come to Atlantic City this week-end and take part in the program.

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Due to the untimely death of its Chairman, Dr. C. D. Smith, the Section on Gastro-Enterology of The Medical Society of New Jersey has found it necessary to make changes in its panel of officers. Dr. Jacob Mathesheimer of Jersey City has been designated as Acting Chairman, and his position as secretary has been assigned to Dr. H. R. Wesson of Montclair as Acting Secretary.

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The American Urological Association offers an annual award "not to exceed \$500.00" for an essay on the result of some specific clinical or laboratory research in urology. The prize is based on the merits of the work presented. Competitors shall be limited to residents in urology in recognized hospitals or to urologists who have been in special practice for not more than five years.

Essays should be in the hands of the Secretary, Dr. Clyde L. Deming, 789 Howard Avenue, New Haven, Conn., on or before April 1, 1942. For further information, write to Dr. Deming.

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A Primer on Diabetes has been published by the Medical Society of Pennsylvania. This 36-page brochure may be obtained from the Secretary of the Society at 230 State Street, Harrisburg, Pennsylvania. It reviews the physiology and symptomology of diabetes, discusses detailed programs of insulin therapy, advises on the calculation of diet and on the treatment of emergencies, and provides a number of useful height, weight and diet tables.

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Fellowships for research in nutrition have been announced by Swift & Company of Chicago. The fellowships provide for special research to be undertaken in the laboratories of medical schools with funds set aside by the Company as grants-in-aid. Further information may be secured from Dr. W. H. Lipman, Swift & Company, Chicago, Illinois.

COUNTY SOCIETY REPORTS

ATLANTIC COUNTY

Sloan G. Stewart, M.D., Reporter

Once again the Army and the health of the registrants was the topic for discussion at the regular monthly meeting of the *Atlantic County Medical Society*, on November 14 at the Traymore Hotel. DR. LEONARD G. ROWNTREE, Chief of the Medical Division of the Selective Service System and a Colonel in the U. S. Army Medical Reserve Corps, was the principal speaker. His is a large and important task in keeping the medical problems of the draft in the hands of the physician, and especially in the handling of the rejected men who need rehabilitation. The causes of these rejections were analyzed statistically, and it was emphasized that because army standards were kept high, a large proportion of the rejectees could be easily put in condition to pass a reexamination for the army with a little medical or dental care.

Colonel Rowntree announced that President Roosevelt approved of the strict standards of the army and that his major interest was in the rehabilitation of some 200,000 rejected men who could easily be rehabilitated. His plan is to have this done locally by the doctors, the project to be financed by government funds. It was stated that the President was pleased with the fine response of the doctors and dentists. A survey indicated that 65 per cent of these rejected men would voluntarily consent to rehabilitation for the army.

Such a program will be launched soon and it will be a golden opportunity for the medical and dental professions. It will be of benefit not only to the army but also to the public in general, for its purpose is to prevent disease in its early stage and this can be done only by routine examination. It is a rare opportunity to keep control of this phase of the defense program and to serve the people in a new way in a new field.

This very inspiring talk was discussed by Drs. Barbash and Scanlan. DR. DAVID ALLMAN spoke of promoting the sales of defense stamps and bonds, and introduced Mr. John Manning, State Administrator for Defense Savings Bonds and Stamps. He described the buying of these bonds as a method of combating national spending. DR. HARRY SUBIN, President of the County Medical Society, adjourned the business meeting at 11 p. m.

BURLINGTON COUNTY

T. B. Dickson, M.D., Reporter

The annual meeting of the *Burlington County Medical Society* was held on November 13, 1941, at the Moorestown Field Club in Moorestown.

DR. DEAN LEFAVOR welcomed to the meeting Dr. R. R. Betancourt of Camden County; Drs. Diverty, Wood and Nelson of Gloucester County; Dr. Lloyd Green of Philadelphia; Dr. Hebble of Moorestown; and Dr. Sutton, a resident of the Burlington County Hospital.

The guest speaker, DR. EDWARD WEISS, Professor of Clinical Medicine at Temple University Medical

College of Philadelphia, was introduced by DR. FREEMAN METZER. Dr. Weiss' topic was "Hypertension and Nephritis". He stated that at present the subject of hypertension is confused due to recent advances in research. He showed how hypertension and nephritis are sometimes related to each other. Surgical procedures have not proved their worth in the treatment of hypertension except in the malignant form, when it may be tried. Dr. Weiss explained that hypertension was a highly complex condition woven into the pattern and make-up of the individual.

Many members entered into the discussion which followed.

The Chairman of the Medical Preparedness Committee, DR. HARRY L. ROGERS, announced that he had received a letter from Dr. C. H. Schlichter, Chief Surgeon of the New Jersey Medical Emergency Service, who requested that a physician be appointed in each district to serve as coordinator of the emergency agencies, with the title of Local Chief Surgeon of Medical Emergency Service. The following appointments were made by Dr. Rogers and were approved by the County Society:

Dr. J. M. Davis—Burlington

Dr. P. M. Scott—Beverly

Dr. H. P. Shipps—Delanco and Riverside

Dr. C. S. Mills—Riverton and Palmyra

Dr. N. Thorne—Moorestown and Maple Shade

Dr. J. H. Hornberger—Roebling, Florence and Bordentown

Dr. M. W. Newcomb—Browns Mills and New Lisbon

Dr. E. L. Small—Medford and Marlton

Dr. E. R. Haldeman—Mt. Holly

Dr. R. Frank—Pemberton

Dr. E. V. Davis—Vincentown

Dr. A. B. Peacock—Columbus

The following officers were elected for the Burlington County Medical Society for 1942:

President-Elect—Harry Mark

Vice-President—Luther M. Hartman

Secretary—E. Warren Rodman

Treasurer—Anthony V. Ziccardi

Reporter—T. Bruce Dickson

Censor (3 years): R. Winifred Betts

Delegates to State Society (3 years): Edgar J.

Haines, F. D. Fahrenbruck

Alternates to State Society (3 years): Arthur B.

Peacock, William E. Bray

Nominating Committee, State Society: Edgar J. Haines

Alternate Member, Nominating Committee, State Society: Daniel F. Remer

Delegates to Camden County: H. P. Shipps, E. V. Davis

Delegates to Atlantic County: E. L. Small, L. Viteri

Delegates to Gloucester County: D. H. B. Ulmer, H. Curtis

Delegates to Ocean County: R. Frank, W. Bray

Delegates to Salem County: R. Imhoff, S. Emlen Stokes

Delegates to Cape May County: E. R. Hunter, R. I. Downs

Members of Committee on Program and Arrangements (to 1944): Eugene Meyers, Thomas J. Summey

Member of Nominating Committee (3 years): R. E. Haldeman.

The reports of the several committees were read by their respective chairmen and all have shown much progress.

A new schedule of minimum medical fees was discussed and approved by the County Society. Each member will receive a copy thereof. The new schedule is to be effective December 1, 1941.

The Annual Winter Dance given by the physicians of Burlington County will be held on December 13, 1941, in the Mt. Holly Armory.

CAMDEN COUNTY

Harold D. Barnshaw, M.D., Reporter

The *Camden County Medical Society* held its first meeting in the City Dispensary Building on October 7, 1941, with Dr. A. L. Stone presiding.

DR. BERNARD L. COMROE presented an interesting, illustrated talk on "Practical Pointers in the Treatment of the Arthritic Patient". This was discussed by Dr. Lewis and Dr. Gilbert.

Karl S. Russell, M.D., 219 New Jersey Avenue, Collingswood, was approved for active membership.

Dr. Hirst presented the following memoir of Dr. Alfred M. Elwell, who died on May 24, 1941, at Ocean City, N. J.:

"DR. ALFRED MAUL ELWELL was born in Bridgeton, N. J., on November 11, 1876. He died at his summer home in Ocean City, N. J., on May 24, 1941.

"His early education was acquired in the public schools of Bridgeton and at the West Jersey Academy in the same city, from which he graduated in 1895. His medical degree was taken at the Medical Department of the University of Pennsylvania in 1899.

"After graduating in medicine, Dr. Elwell practiced one year in Uniontown, Pennsylvania; and thereafter became associated with the late Dr. Ireland, of this city, which very pleasant association lasted until Dr. Ireland's death. After this Dr. Elwell established his office at 407 Cooper Street.

"Always interested in diseases of the nose, throat and ear, Dr. Elwell soon formed a contact with Dr. Walter Roberts at the Methodist Hospital in Philadelphia. These men had a very high regard for each other, and the association proved to be a very happy one of years' duration.

"Soon after this he became associated with the Cooper Hospital as otolaryngologist and was held in very high esteem by the members of the Attending Staff.

"Dr. Elwell was a diplomate of the American Board of Otolaryngology. He had a large clientele, many of whom remained his friends and patients during his entire life.

"In 1915, March 20th, Dr. Elwell married Helen Robbins Whitaker, who bore him two sons, Alfred M., Jr., and Roberts W., all of whom survive him."

Dr. Schrack presented the following memoir of Dr. William Haines:

"We regret the passing of DR. WILLIAM HAINES of Audubon on July 5, 1941. Dr. Haines was born in Clarksboro, Gloucester County, N. J., on December 11, 1885. He received his secondary education at private schools and was graduated from the Philadelphia College of Pharmacy. Then he entered Jefferson Medical College, from which he was graduated in 1912. His internship was at Allegheny General Hospital, Pittsburgh.

"After practicing for a short time in Ohio, he settled in Audubon, where he practiced medicine for twenty-seven years. He was appointed to the faculty of the Jefferson Medical College as Assistant Instructor in Diseases of the Chest.

"Dr. Haines was a captain in the U. S. Army from 1917 to 1920, and a member of the National Veterans Bureau 1920-1928. In October, 1940, he was appointed a member of the Medical Advisory Board Number 12 of New Jersey.

"His immediate family is interesting in its medical connection. His wife, Dr. Mabel Haines, is a practicing physician in Audubon. Two sons have recently graduated from Johns Hopkins Medical School, and are serving residencies in the Johns Hopkins Hospital. A younger son will enter medical college next year.

"Dr. Haines served as a member of the Board of Health of Audubon for a number of years. He was a member of the A. M. A. and of his State and County Societies."

Dr. German presented the following memoir of Dr. John A. Gilson, Jr.:

"JOHN ALOYSIUS GILSON, JR., was born on January 19, 1907, in Philadelphia. His parents were the former Anna McBride and John A. Gilson, Sr.

"His family moved to Haddon Heights, New Jersey, where he attended the public schools.

"All through his life he was particularly interested in Boy Scout activities, and he, himself, was an Eagle Scout. He served actively on the Scout Executive Board of Camden County for a number of years.

"He was graduated from St. Joseph's High School in 1924, and St. Joseph's College in 1928. He then entered St. Louis University to study medicine. After two years he received a fellowship at the university, where he majored in pathology.

"He was graduated from St. Louis University School of Medicine in 1934, and interned at St. Agnes' Hospital in Philadelphia.

"He opened an office for general practice in Haddon Heights, N. J. He was elected to the Staff of Cooper Hospital, Camden, and for more than two years performed most of the autopsies for Camden County. He was Assistant Pathologist at St. Agnes' Memorial Hospital, Philadelphia, where he was also engaged in the field of ear, nose and throat.

"Dr. Gilson was a member of the Camden County Medical Society, The Medical Society of New Jersey, and a Fellow of the American Medical Association. In September, 1940, he was appointed Pathologist and Director of the Laboratory at the Doctors' Hospital, Philadelphia.

"He married Cecilia Clarke of Audubon, N. J., on September 14, 1933. A child, Mary Cecilia Gilson,

was born on June 10, 1934. His wife died at St. Agnes Hospital in September, 1935. In 1938 he married Ellen Gooley of Haddon Heights. A son, John 3rd, was born on August 30, 1939.

"Dr. Gilson died on July 14, 1941, at the Doctors' Hospital of uremia, following a long illness due to hypertension and chronic nephritis.

"Beside his immediate family, Dr. Gilson is survived by his mother, two sisters and five brothers."

CAPE MAY COUNTY

Clarence W. Way, M.D., Reporter

A regular meeting of the *Cape May County Medical Society* was held on November 14 at the Douglass Hotel, Wildwood. Members present were Drs. Herschell Pettit, G. F. Dandois, A. J. Friedland, H. H. Hornstine, Samuel Hughes, Frank Hughes, Margaret Mace, George Brooks, Ida Monosson-Friedland, Aldrich Crowe, J. B. Townsend and W. D. Robbins. Also present was Mr. Friel.

A letter received from the family of the late DR. SAMUEL GIDDING expressing appreciation for flowers was read. Dr. G. F. Dandois and Dr. Samuel Hughes were appointed a committee to draft a resolution of condolence and send it to the family of Dr. Gidding.

It was moved by DR. F. HUGHES and seconded by Dr. Mace that the Secretary write Mr. Henry Clouting and ask that a second county nurse be appointed. Motion carried.

A letter was read from the State Public Relations Committee saying that Dr. Dandois had spoken before the Kiwanis Clubs of Wildwood and Cape May on "The American Way".

It was announced that DR. MORRIS FISHEIN, Editor of the A. M. A. Journal, would speak in Atlantic City at the Traymore Hotel on January 16, 1942, at 9:00 p.m.

On motion by DR. MARGARET MACE, seconded by Dr. F. Hughes, a resolution was unanimously passed authorizing the Secretary to write to the State Department of Health, Trenton, saying that the Society favors continuation of the venereal disease work and approves appropriation of more funds for this purpose.

Applications for membership were received from three physicians. Action on these will be taken at the next meeting.

ESSEX COUNTY

Paul H. Hosp, M.D., Reporter

The regular monthly meeting of the *Essex County Medical Society* was held November 13 at the Academy of Medicine. DR. FRANCIS WEBER, President, called for order at 9 p.m. After the reading of the minutes of the previous meeting and those of the Council held in the interim, the meeting was turned over to the Child Welfare Committee.

DR. HARROLD A. MURRAY, Chairman, introduced the speaker, DR. MARTHA ELIOT, Medical Director of the United States Children's Bureau. She took for her topic "Child Health in the Defense Program". Dr.

Eliot had studied England's facilities for child and maternal welfare during a visit to England earlier in the year. She reported that the evacuation of children, mothers and expectant mothers was well handled there and that the standards set up were high as to personnel, nursing homes and hostels. Evacuation has saved untold lives. She explained how these methods could be applied in our country, and suggested that we have blueprints ready. Such plans will also help solve many problems in peace time.

DR. STANLEY NICHOLS gave us an idea of what New Jersey is doing at present in this work. DR. JULIUS LEVY remarked that many of the suggestions which are war measures are good as permanent projects. DR. STANLEY ROLFE, Superintendent of the Newark School System; DR. A. W. BINGHAM, DR. E. W. SPRAGUE, DR. CHESTER BROWN and DR. S. RUBINOW gave their views on this important subject.

Following the suggestion of DR. M. F. HUBACH of Bloomfield, the Society and Council approved the issuance of a large certificate of membership suitable for framing, to be distributed to members as they pay their 1942 dues. It is hoped that members will display these certificates in their waiting rooms.

The Hospital Service Plan is holding the attention of officers and members at this time, particularly with reference to the possibility of combining plan 2 of the Medical Service Administration with the Hospital Insurance policy. The Essex County Medical Society has scheduled a special meeting on December 2 to consider this important subject.

Elected to membership in the Essex County Medical Society at the November 13 meeting were Drs. T. P. Burrus, Charles H. Flax and J. J. Hamley, all of Newark, and Dr. Adam J. Rapalski, now at the Station Hospital at Aberdeen, Maryland.

Elected to associate membership at the same meeting were Drs. Alfred Fritsch and Maximilian Silberman of Newark, Dr. A. E. Holderith of Livingston and Dr. Emil Kaney of Allwood, N. J.

HUDSON COUNTY

John N. Connell, M.D., Reporter

A regular meeting of the *Hudson County Medical Society* was held on November 5 in Jersey City, with the President, DR. A. J. CONTY, in the chair.

A memorandum from the Chairman of the Finance and Budget Committee of The Medical Society of New Jersey, with reference to the remittance of dues from members in the U. S. Armed Forces was read and approved.

An announcement of the Fourth Annual Clinical Conference was read.

The following applicants were elected to membership in the Hudson County Medical Society: Dr. Milton Blum, Dr. Vincent Campana, Dr. Robert Rubenstein and Dr. Benjamin Starr of Jersey City; Dr. Sidney Boyers of Union City; Dr. Thomas Gleason of Bayonne; Dr. Clifford Kanengiser of North Bergen, and Dr. Sidney Woltz of Weehawken.

The essayist of the evening was DR. MARION B. SULZBERGER, Associate Professor of Dermatology of

Columbia University, who spoke on the "Management of Some Common Dermatoses". The paper was discussed by Dr. C. E. McNENNY and Dr. WILBUR SACHS.

Dr. ELIAS J. MARSH, President-Elect of The Medical Society of New Jersey, briefly addressed the Society on the importance of encouraging scientific programs by local members.

Dr. LEROY A. WILKES, Executive Officer of The Medical Society of New Jersey, spoke on current trends towards organized medical service.

Dr. NORMAN M. SCOTT, Medical Director of Medical Service Administration, discussed the progress of the Plans of that Administration, and asked the Hudson County Medical Society to approve a resolution requiring the Medical Service Administration to make no contracts except in a form endorsed by the local county medical society, and to approve a second resolution requiring physicians and surgeons who are enrolled in the Administration to be reasonably available for fulfillment of contract. Both these resolutions were adopted by the Society.

Dr. Scott also asked the Society to approve the agreement between the Hospital Service Plan of New Jersey and the Medical Service Administration. This resolution was also approved.

There being no further business, the meeting adjourned at 12:30 a.m.

HUNTERDON COUNTY

Jack E. Shangold, M.D., Reporter

The regular meeting of the *Hunterdon County Medical Society* was opened with a delicious steak dinner on Tuesday evening, October 28, at the Ryland Inn in Whitehouse. There were thirteen members and five guests present. Guests of honor included several State Society officers: Dr. Elias J. Marsh, President-Elect; Dr. Joseph F. Londrigan, Second Vice-President; Dr. Alfred Stahl, Secretary; Dr. LeRoy A. Wilkes, Executive Officer, and Dr. James Norton, of the Board of Trustees.

The guests graciously joined in the discussion, thus aiding in clarifying several matters. After the minutes of the previous meeting were accepted as read by the Secretary, Dr. LANE, committee reports were made. The Executive Secretary, Dr. FUHRMANN, read the revised By-Laws, which were unanimously accepted as corrected, and announced that copies of the revisions had been sent to all members. By a vote of those present, the Treasurer, Dr. BOOTHBY, was granted permission to defray small accounts without the necessary approval of any subsequent meeting.

Feature of the evening was a discussion led by the President-Elect, Dr. JENKINS, on the joint meeting of the Medical Service Administration and the New Jersey Hospital Plan. Several plans for bringing medical care to the indigent were formulated.

The meeting was closed after the reading of a letter received by the presiding officer, Dr. Germain, from Dr. Watson B. Morris, General Chairman of the Clinical Conference Committee. In his letter

Dr. Morris invited the component society to Elizabeth on December 3, to attend the Fourth Clinical Conference of The Medical Society of New Jersey.

MONMOUTH COUNTY

By Murray Woronoff, M.D., Reporter

With Dr. BARCLAY MOFFAT presiding, the monthly meeting of the *Monmouth County Medical Society* was held at the Garfield-Grant Hotel, Long Branch, on October 22. The room was filled to capacity. A few announcements were made and then the meeting was turned over to Dr. F. J. Altschul, who introduced the speaker. Dr. JOSEPH JORDAN ELLER of New York spoke on "Dermatology in General Practice". He gave a practical talk and covered many of the newer concepts in dermatology. Dr. W. J. Jamison discussed the paper.

MORRIS COUNTY

Wilbur M. Judd, M.D., Reporter

A large number of physicians and pharmacists attended a joint meeting of this Society and the Morris and Somerset Pharmaceutical Association at Greystone Park, November 13, 1941, with President Teller of the Morris County Medical Society in the chair.

Resolutions, the result of the recent meeting of the House of Delegates in reference to the agreement between the Medical Service Administration and the New Jersey Hospital Plan, concerning the payment for medical and surgical services, were read and unanimously approved after Dr. Sherman, of the House of Delegates, presented a detailed report in which the plan changes were outlined.

Dr. CHESTER I. ULMER, Chairman of the Joint Committee on Professional Relations of The Medical Society of New Jersey, spoke on "Physicians, Patients and Prescriptions" in a most impressive manner, being especially well qualified in view of his experience as a pharmacist before becoming a physician. His remarks advising the use of official preparations, and concerning the attitudes of patients toward their prescriptions, were pertinent.

In conclusion, he paid a tribute to the local pharmacists who give fine service and enjoy ethical relations with the medical profession.

Dr. ROBERT P. FISCHER, Secretary and Chief Chemist of the Board of Pharmacy of the State of New Jersey, gave a historical resume of "Magic and the Bottle", and the development of the relationship between the physician and pharmacist. He referred pointedly to radio, newspaper and other advertising of medication, and the dangers of self-medication in the hands of laymen. The New Jersey Formulary was hailed as an attempt to answer the current demand for standard products.

There was an attractive display of New Jersey Formulary Preparations, the work of the Joint Committee on Professional Relations of The Medical Society of New Jersey and the New Jersey Phar-

maceutical Association, in which the elimination of trade names, and specifying "N. J. F." preparations, was stressed.

OCEAN COUNTY

L. W. Falkinburg, M.D., Reporter

The regular meeting of the *Ocean County Medical Society* was held on November 12 in the Royal Pines Hospital in Pinewald.

The usual preliminary business was transacted after which a guest speaker, MR. MONIOT, explained to the Society The Hospital Service Plan of New Jersey, and set forth its advantages to individuals or groups.

PASSAIC COUNTY

I. Okin, M.D., Reporter

DR. THOMAS K. LEWIS, President of The Medical Society of New Jersey, and DR. LEROY A. WILKES, Executive Officer, were speakers at the regular meeting of the *Passaic County Medical Society* on Thursday evening, November 13, 1941. The subject was "State Medicine—Its Trends". DR. SIGURD W. JOHNSEN presided.

DR. WILKES briefly outlined the history of The Society in relation to economic problems in medicine and pointed out that the problem is to distribute medical care to those who are not looking for it at the present time and also to give adequate care at moderate rates. The high professional quality of medicine must not be impaired, he said.

DR. LEWIS then said that the term "State Medicine" was a very vague one, difficult to define. He interpreted it as the encroachment of the government on the individual practice of medicine, based on the assumption that regimentation of medical activities was planned. He felt that as long as the United States had not become socialized, this form of regimentation would never occur. Some forms of State Medicine have always been present as exemplified by the health department and the state institutions; and physicians understand that these governmentally controlled agencies are for the public good. No other state in the union has such reciprocal respect between government and physicians as New Jersey. However, physicians cannot expect to continue peacefully as in the past; that, in the rebuilding of a shattered world after the present war, we must play an important part. Organized medicine has been far ahead of the government in elevating our standards and maintaining them. The theme of the medical profession has been the welfare of the people of America.

The latest type of reform is concerned with the availability of medical care. Many cannot pay for this care at present and the representatives of The Society have been studying this problem for the past ten years. He pleaded for complete faith in our committees, who have been active in this study. Dr. Lewis then went on to explain the Medical Service Administration and how hospital and doctor bills would be paid under this plan. This insurance plan will parallel the existing hospital plan.

Many questions were asked and there was a lively

discussion. All amendments and the proposed resolution to the Medical Service Administration plan were adopted.

RESOLUTIONS

The following resolution on the death of Dr. William E. Chase was unanimously accepted:

Whereas, Members of the Passaic County Medical Society feel a deep and sincere regret on the death of DR. WILLIAM E. CHASE;

Whereas, He served for many years as an eye specialist to the people of Passaic and New York City with great skill and patient effort;

Whereas, His fine personality and friendliness made him loved by all who knew him and his deep civic interest was appreciated by his fellow citizens;

Whereas, It has pleased the Divine Creator to call unto Himself our colleague and friend, we, the Passaic County Medical Society, deeply mourn the loss of our late colleague, Dr. William E. Chase, and extend our heartfelt sympathy to his loyal and devoted wife, Mrs. Florence Finch Chase, and to the other members of his family;

And Be It Resolved, That his resolution be spread in full upon the minutes of this meeting and a copy thereof sent to his family.

Signed: A. W. VAN RIPER, M.D.

A. H. TEMPLE, M.D.

THOMAS GLASGOW, M.D.

IRVING OKIN, M.D.

The following resolution on the death of Dr. Carroll Dean Smith was also unanimously accepted:

Whereas, It has pleased the Divine Creator in His Infinite Mercy to call unto Himself DR. CARROLL DEAN SMITH, in the prime of his life and early in his career;

Whereas, His skill, his devotedness and conscientiousness in the execution of all his duties promoted his successful and well-established practice, and made him honored and respected by all;

Whereas, His sudden death has come as a distinct shock to his family, his numerous friends, patients, and members of his profession, We, the Passaic County Medical Society, adopt the following resolution:

Be It Resolved, That the members of the Passaic County Medical Society deeply mourn the loss of our late colleague, Dr. Carroll Dean Smith, and extend and express our heartfelt sympathy to his loyal and devoted wife, Mrs. Dorothy Smith, and to the other members of his family;

Be It Resolved, That this resolution be spread in full upon the minutes of this meeting and a copy be sent thereof to his family.

Signed: W. W. SUTHERLAND, M.D.

R. J. McDONALD, M.D.

ELECTIONS

The following Trustees were reelected to the Board of the Medical-Dental Service Bureau:

Jacob Roemer, M.D. William Spickers, M.D.

Harry Wolfson, M.D. Sigurd W. Johnsen, M.D.

Leon E. DeYoe, M.D. Norman M. Dingman, M.D.

D. P. D. Jackson, M.D., Little Falls (transfer from

Warren County) was elected to Active Membership and the following to Associate Membership:

Sol B. Goldman, M.D., Paterson
Marion Frank Kaletkowski, M.D., Passaic
Ralph Cady Yeaw, M.D., Paterson

AMENDMENTS

The following amendments to the Constitution and By-Laws were adopted:

Delete the present Article III of the Constitution and substitute the following:

Article III, Section I—Every legally registered Physician having the degree of Bachelor of Doctor of Medicine who is in good moral and professional standing shall be eligible for active or regular membership. Various types of membership may be provided for in the By-Laws.

Article III, Section II—Any Physician not eligible to active or regular membership but having the degree of Bachelor or Doctor of Medicine who is a graduate of a school approved by the New Jersey State Board of Medical Examiners and who is in good moral and professional standing shall be eligible to Courtesy Membership.

Add to Chapter I, Section I-D of the By-Laws:

Any Physician of good moral standing, holding a degree of Bachelor or Doctor of Medicine, granted by a College of Medicine recognized for licensure in the State of New Jersey by the Board of Medical Examiners, but who does not hold a license to practice in New Jersey, is eligible for Courtesy Membership.

A large group of members was present at this meeting.

SALEM COUNTY

Lee C. Hummel, M.D., Reporter

On October 17, 1941, the second meeting of the *Salem County Medical Society* was held at the Greystone Inn, Woodstown, N. J., Dr. E. E. Evans presiding.

There being little business to transact, the meeting was turned over to our guest speaker, Dr. EDWIN RISTINE of Camden, N. J. His subject, "Early Diagnosis of Gastro-Intestinal Carcinoma", was of great interest as about 50 per cent of all carcinomas are found in this tract and early diagnosis is of great importance if cure is to be attained. The paper was discussed by Dr. D. W. Green and Dr. L. C. Hummel.

DR. E. E. EVANS gave an informal talk on the work being done at the DuPont plant for the men employed in the anilin dyes. He described the cystoscopic examinations and laboratory tests made

to check on the growth of bladder tumors which are particularly prevalent in this group.

Dr. Charles Savage of Pennsgrove, N. J., and Dr. Francis Sayres of Ziegler Tract were elected to membership.

Dinner was served at the Greystone Inn to fifteen members of the Society.

WARREN COUNTY

Philip B. Kassow, M.D., Reporter

Twenty members attended the annual election meeting. The following officers were elected:

President: Neumann C. Marlett
Vice-President: Guernsey West
Secretary: Ralph Buchanan
Treasurer: A. C. Zuck
Reporter: Philip B. Kassow
Censor: Seymour Kimmel

Delegate (3 years): W. H. Varney

Alternate Delegate for H. B. Bossard: Paul F. Drake

Alternate Delegate for Neumann Marlett: Ralph Buchanan

Alternate Delegate for W. H. Varney: Guernsey West

Dr. D. M. Shevitz of Hackettstown was elected a member of the society.

It was announced that Dr. A. Z. Domine had moved to Wisconsin and Dr. D. F. Jackson had moved to Little Falls, N. J.

DR. LEROY WILKES presented the "News Behind the News" of the Medical Service Plan. He stated that coöperation is essential.

DR. GEORGE WYCKOFF CUMMINS, octogenarian physician, who practiced medicine in Belvidere, N. J., for fifty-one years and who had been a member of our Society for fifty years, was honored on November 12, 1941, at a testimonial dinner given by the Society at Hotel Belvidere. The guest of honor was presented with a watch fob charm and a certificate of life membership. Mrs. Cummins presented our Society with a volume of the history of the Warren County Society since 1765. Felicitations and greetings were given by DR. THOMAS LEWIS, President of the State Society, and DR. W. F. COSTELLO, Chairman of the State Board of Trustees.

NEW JERSEY CHAPTER OF THE AMERICAN COLLEGE OF CHEST PHYSICIANS

Charles I. Silk, M.D., Secretary

Under the chairmanship of the Vice-President, Dr. Clyde M. Fish, an important business meeting was held October 23, 1941, at Newark, N. J. The revised constitution and by-laws were presented, read and ratified. Thirteen members attended.

A program committee of three members, to be appointed by the President, was authorized in preparation of the Annual Meeting of the College which is to be held in Atlantic City in 1942. New Jersey will be the host state for this meeting.

BOOK REVIEWS

New Jersey Formulary. By the Joint Committee of Professional Relations of The Medical Society of New Jersey and the New Jersey Pharmaceutical Association, Chester I. Ulmer, M.D., Chairman; Robert P. Fischell, Ph.D., Editor. Fourth Edition. 1941.

The physician who makes wide use of this pocket manual will be doing a three-fold good turn. He helps his patient by prescribing relatively inexpensive medication; he helps himself because he does not incur the ill will of the pharmacist or the patient, which often results when over-priced proprietaries are called for; and he helps the druggist because the wider use of this Formulary would reduce the need which retail pharmacists now feel for having enormous stocks of differently branded but pharmacologically similar preparations on hand.

The Formulary is a 64-page manual listing suitable preparations for disorders of the nose and throat, for coughs and colds, for sedatives and analgesics, for gastro-intestinal disturbances, and for several other common ailments. A ready reference index makes it possible for the doctor to find the desired preparation quickly. The usefulness of the Formulary is further enhanced by a table of dosage equivalents and a series of practical suggestions to doctors. The type is clean, the paper of good quality, and the printing is legible.

Adequate space is given to the newer vitamin preparations, and every prescription is accompanied by a working formula for pharmacists.

All druggists are prepared to recognize and supply prescriptions listed in this manual, and if the doctor will write "N. J. F." after the title, the druggist will definitely conform to the exact standards set by the Joint Committee.

The New Jersey Formulary is a visible achievement of which Organized Medicine and Organized Pharmacy may properly be proud.

Traumatic Neuroses of War. By Abram Kardiner, M.D. Pp. 258. New York, 1941. Paul B. Hoeber, Inc. Price: \$3.50.

"The traumatic neurosis," says Kardiner in his introduction, "bids well to be one of the commonest neurotic disturbances in the world." As yet, this is not true of these United States, though the glutting of our courts and compensation bureaux with such cases suggests that we are rapidly getting there. Certainly a war, with the precipitation of neuroses among both soldiers and civilians will enormously add to this problem.

Kardiner's book is sponsored by the Division of Anthropology and Psychology of the National Research Council. It is divided into three sections: clinical, theoretical and practical. The clinical section is devoted to a review of the symptoms of the traumatic neuroses. The theoretical section is Freudian without being esoteric. In the "practical" division, the author reviews the diagnosis, prognosis treatment and forensic aspects of traumatic war neuroses.

Attention is given to such treatment techniques as sedation, rest, psychoanalysis, hypnosis, nursing care and emotional reëducation. Also considered is the problem of "mass treatment", that is giving treatment to large numbers of psychoneurotics at one hospital. Attention is paid to such mechanical details as the organization and personnel distribution in the hospital. The effect of war trauma on civilian morale, and the forensic and pension-aspects of traumatic neuroses are reviewed.

While the book will appeal most directly to the army or navy doctor, it is a valuable work for the civilian practitioner, too, since the management of traumatic war neuroses is little different from the treatment of traumatic neurosis in civilian and industrial life. And to the Veterans' Administration physician, Kardiner's book might well be a desk-manual.

The Microbe's Challenge. By Frederick Eberson, Ph.D., M.D., Director of Laboratories, Pathologist, Gallinger Hospital, Washington, D. C. 354 pp. \$3.50. The Jaques Cattell Press, Lancaster, Pa.

That the general public displays a lamentable ignorance of the mechanism of disease in its broad aspects has long been recognized; hence the many efforts, of varying effectiveness, to educate the laity in these matters. To this end there has been a recent flood of books, of which this volume is one.

The theme of this book is the contest between man, in his attempts to control disease, and the bacterial agencies which, in many instances, play so important a part in the cause of disease.

It is difficult to express this in terms readily understood by the general public, particularly if one is to cover, not merely the highlights, but the complexities of the subject. Dr. Eberson has made a valiant and, in the main, highly successful endeavor to achieve this objective. He is to be congratulated for his avoidance of the melodramatic and hysterical approach common to the de Kruif school of "popular" medical writing. He neither "writes down" to his audience nor "over their heads". He has presented his subject in a plain, sane and common sense manner and has succeeded in writing an informative and authoritative story of the development of bacteriology in its relation to disease and of the development of methods for the control and management of epidemic infections of both virus and bacterial origin.

Dr. Eberson makes plain that the microbe, as well as man, can adapt itself to its environment, and hence that, despite the advances which have been made, the struggle between the two is in its infancy.

This is a good book for the intelligent, adult reader and may well be added to the physician's library. The list of "Suggested Readings" at the end of the book will be of especial interest to the doctor.

ROBERT A. KILDUFFE, M.D.

Treatment of Infantile Paralysis in the Acute Stage. By Elizabeth Kenny. Cloth. 285 pp., 63 illustrations. \$3.50. The Bruce Publishing Co. 1941. Milwaukee, Wis.

It has been the consensus of authorities that the treatment of the *acute* stage of poliomyelitis should be characterized by immobilization and rest of the affected muscles and masterly inactivity until the acute stage is over.

Within recent years, Miss Kenny, an Australian nurse, has proposed—and practiced—a revolutionary and, what seems, at first glance, a radical departure from this principle. Based upon the belief that the all-important factor in infantile paralysis was to overcome muscle spasm and what Miss Kenny describes as incoördination, the Kenny method dispenses with all supports, opposes immobilization and begins active and passive motion at once.

In this book, which presents her method in detail, she describes her technic and its results.

The general tenor of the book is somewhat polemic, which is natural in view of the conservative reception thus far accorded her work. Certainly, her *modus operandi* and the principles upon which it is based are diametrically opposed to those of the vast majority of orthopedists and physiotherapists concerned with the treatment of infantile paralysis. As such, there is a natural reluctance to subscribe to her theory.

Like every new theory, the Kenny method can be finally evaluated only upon the basis of time and trial. The book is of interest as presenting the method in toto and in detail but, in this reviewer's opinion, would benefit by elimination of the "testimonial" atmosphere which unduly pervades the book.

Whether the Kenny method is good, bad or indifferent remains to be seen.

DAVID B. ALLMAN, M.D., F.A.C.S.

Shock Treatment in Psychiatry. By Lucie Jessner, Ph.D., M.D., and V. Gerard Ryan, M.D. Pp. 155. Grune & Stratton, Inc., New York. Price: \$3.50.

So long as the psychiatrist had nothing to offer beyond custodial care and hydrotherapy, his position in the medical family was equivocal. With the introduction of fever therapy for paresis, the psychiatrist was, for the first time in the twentieth century, able to take major part in a significant procedure. Shock therapy now adds another technique which falls exclusively in the realm of the physician; there need be no fear of inroads by psychologists and lay advisers.

The literature on shock therapy is so large that the doctor cannot see the trees for the forest. The practitioner who wants to know exactly how insulin dosage is calculated in dementia praecox, who wants to know the chance of recovery from manic-depressive psychoses by metrazol convulsive therapy, who wants to know just what is done to produce electric shock convulsions, is at a loss when he turns to standard literature because of its very richness. The Jessner-Ryan manual is therefore very welcome. In this small book is compactly condensed

the down-to-earth facts about this rapidly growing psychiatric weapon. The authors describe the exact techniques of the three chief forms of shock therapy (insulin, metrazol and electric shock), discuss dosage, preparation of patient, modifications, management of complications and length of treatment. Rates of improvement and relapse are carefully evaluated. Little space is wasted in idle speculation as to the theoretical basis for the results, although a bibliography of more than 350 references is appended to the volume for those who wish to investigate the academic side of the problem more thoroughly.

The Premature Infant; Its Medical and Nursing Care. By Julius H. Hess, M.D., and Evelyn C. Lundeen, R.N. Pp. 309. Philadelphia, J. B. Lippincott Company. 1941. \$3.50.

Previously published work of these distinguished authors is summed up and some new material offered in this volume. Practical considerations are stressed and the detail of nursing care and treatment as well as of provisions for care of premature infants at home or in transport will make this text an invaluable aid to hospitals and health authorities. There is much for the physician, too, in the chapters on development and disorders peculiar to premature newborns. Description of measures for oxygen therapy and the discussion of anemia merit particular attention.

The remarks about the cause of premature births are admirably correct but the implication that early termination of pregnancy can be explained in all cases is erroneous. Careful studies, this reviewer believes, leave more than 50 per cent of premature births of uncertain etiology. In prevention of premature labor in women who have neither twins, toxemia, syphilis nor gross placental abnormality lies the hope of material reduction in the number of early neonatal deaths.

ROBERT A. MACKENZIE, M.D.

Orbital Tumors; Results following the transcranial operative attack. By Walter E. Dandy, M.D. Pp. 168. New York, Oskar Piest. 1941. \$5.00.

Prior to the advent of neurosurgery the majority of orbital tumors were operated upon by ophthalmic surgeons, with very limited success, it being found that only tumors in the anterior portion of the orbit could be successfully removed. Appreciating these facts, Dr. Dandy first introduced his combined intraorbital and intracranial approach in 1922. The series of cases presented in this monograph include the routine clinical procedures, the disease present and the results obtained by the combined surgical approach. The disclosure that 75 per cent of this series presented a combined orbital and intracranial involvement, makes it imperative that the neurosurgeon expose all orbital tumors other than those in which intracranial extension is beyond suspicion.

The book is complete in every respect and should be of interest to all ophthalmologists and neurosurgeons.

J. WALLACE HURFF, M.D.

WOMAN'S AUXILIARY

WOMAN'S AUXILIARY

MRS. ASHER YAGUDA, Chairman Press and Publicity

COMING EVENTS

ATLANTIC COUNTY

December 13, 1941, 8:45 p. m.
Residence: Mrs. James H. Mason, Suffolk and
Atlantic Avenues, Atlantic City
Christmas party

BERGEN COUNTY

December 16, 1941, 9:00 p. m.
Hackensack Hospital, Hackensack
Speaker: Mrs. William A. Timberman, Jr.
Subject Flower arrangements

BURLINGTON COUNTY

January 5, 1942, 12:30 p. m.
Newlin's Restaurant, Moorestown
Business meeting
Book review
Luncheon

CAMDEN COUNTY

January 6, 1942, 2:00 p. m.
Place undecided
Red Cross program

HUDSON COUNTY

January 5, 1942, 2:00 p. m.
Tuberculosis Hospital, Clifton Place, Jersey City
Business meeting and tour of hospital
Tea

MIDDLESEX COUNTY

December 17, 1941, 8:30 p. m.
Mrs. Robert Walker, 29 Adelside Avenue, High-
land Park
Christmas masquerade, carol singing and games

"C" Is for Camden County

These articles, written by the Presidents of the County Auxiliaries, are published each month and describe the procedures, aims and pet projects of the County Auxiliaries.

During this Auxiliary year Camden County hopes to renew and strengthen friendships—keep in closer touch with the Medical Society—coöperate in the Medical Defense Program—and continue our regular annual projects.

We hold four regular meetings a year and one Public Relations meeting. At our first meeting Dr. Thomas K. Lewis, President of The Medical Society of New Jersey, outlined the program for the Auxiliary in civilian defense. In January, the Program Chairman plans two speakers, one from Fort Dix and one from the National Red Cross. Our March meeting is to be in the form of a radio broadcast, using our own "talent". We will wind up our year with a luncheon meeting in May.

March is our busy month. We hold our annual card party, usually accompanied by a fashion show, which enables us to give around

four hundred dollars to health charities. This month we also had a Public Relations meeting for the lay groups of the community, having outstanding doctors as speakers.

We purchase each year a group of books on the accepted list and present them to public libraries in memory of deceased Auxiliary members and doctors. We also plan to finish re-arranging and cataloging all the medical books of the County Medical Society.

This is a typical year in the life of the Camden Auxiliary to the Medical Society. We all enjoy it and gain much from it and want to extend an invitation to all Auxiliary members throughout the State to join us whenever possible.

MRS. GEORGE B. GERMAN, President,
Auxiliary to the Medical Society of
Camden County.

IDEA FROM ESSEX COUNTY

Mrs. Frank Bien, Program Chairman of Essex County, has conceived and executed a new plan worthy of the attention of other counties. Many of the monthly meetings of this county are social, general or non-health programs. It has been arranged that when-

ever this is so, one of the members will read a five-minute paper to be written by a physician.

At the November meeting a fascinating article on "Blood Banks" was received with such acclaim by the members that the absence of an applause meter was a shame.

EXECUTIVE BOARD

The regular meeting of the Executive Board of the Woman's Auxiliary to The Medical Society of New Jersey was held in Camden on October 13, 1941.

The meeting was called to order at 10:40 a. m. by the President, Mrs. O. R. Carlander. Minutes of the previous meeting were approved as read. The Treasurer, Mrs. T. P. McConaghy, submitted a statement showing a balance of \$588.10.

The President asked Mrs. H. V. Hubbard to act as Parliamentarian in the absence of Mrs. G. R. Stamps.

The question of establishing a central office was opened for discussion. It was felt that the majority were in favor of a central office but not in favor of increasing the dues. The County Presidents were asked to take this matter up in their individual counties and report to Mrs. Carlander in order that she might speak with full knowledge at the national Board meeting in Chicago.

Mrs. Hunter nominated Mrs. R. J. McDonald as alternate for Mrs. Carlander. Seconded and carried.

The Corresponding Secretary, Mrs. L. L. Glover, reported concerning the number of letters and cards mailed since the last meeting.

REPORT OF THE PRESIDENT

The Recording Secretary was asked to take the chair during the presentation of the President's report. Mrs. Hubbard moved that the report of the President be accepted with thanks.

Mrs. G. N. J. Sommer, President of the Mercer County Auxiliary, invited the Executive Board to hold its January meeting in Trenton.

Mrs. E. W. Sprague, President of the Essex County Auxiliary, stated that they were opening the new addition to the Academy of Medicine and would be most happy to have the Board hold its March meeting in Newark.

The President accepted both invitations.

Mrs. Carlander announced a change in the dates of our Annual Meeting in Atlantic City. The meeting is to be held April 21, 22, and 23.

COMMITTEE REPORTS

Arrangements: Mrs. Carlander stated that Mrs. Ruvane had written to Mrs. Gamon requesting her to arrange for this meeting.

Archives: Mrs. C. Chester Chianese, Chairman, reported that all important papers forwarded to date have been filed at the Executive Offices in Trenton.

Art, Hobby and Medical History: Mrs. Ily R. Beir, Chairman, stated that the medical his-

tory work of this committee is of such importance that it is a major activity.

Bulletin: Mrs. S. H. Jessurun, Chairman, stressed the importance of being well informed concerning all plans and policies of our organization. Information regarding these matters as well as official programs, information relative to home defense, and many other interesting articles will appear in the Bulletin. Mrs. Jessurun's report was read by Mrs. Epler.

Entertainment: Mrs. David B. Allman, Chairman, made a detailed report relative to the expenses of the 1940-41 Annual Meeting. Mrs. Carlander announced that Mrs. Allman had been appointed as Chairman of Entertainment for the National Meeting in Atlantic City.

Finance: Mrs. Chester I. Ulmer, Chairman, presented two budgets—one including \$100 from the Reserve Fund and the other including \$150 from the Reserve Fund. Mrs. Ulmer recommended that we draw \$150 from the Reserve Fund. Mrs. Beir moved that we accept the recommendation of Mrs. Ulmer. Seconded by Mrs. McGuire and carried.

Legislation: Mrs. Max L. Weimann, Chairman, stated in her report that we hope to stress legislative matters in our Auxiliary work. In order to bring about the sort of coöperation our Medical Society desires, we must continue to educate ourselves. Mrs. Weimann urged that the counties have a short quiz period at each regular meeting. Sample questions will be supplied by the state chairman.

Medical Preparedness: Mrs. Luis E. Viteri, Chairman, stated that the object of this committee is to collect information concerning each member; to find out what work she could most capably handle when the various groups are formed. Questionnaires will be sent to each Auxiliary member.

Press and Publicity: Mrs. Asher Yaguda, Chairman, reported that a special appeal was made to the county chairmen to take advantage of every opportunity for publicity in the newspapers and to save the clippings. This year there will be a series of articles written by county presidents. It is also the intention of the Press and Publicity Committee to focus the attention of the National Auxiliary on the accomplishments of New Jersey by sending in a monthly letter to the Journal of the A. M. A.

Printing: Mrs. J. J. McGuire, Chairman, reported on the amount of stationery distributed to officers and chairmen.

Program: Mrs. A. Haines Lippincott, Chairman, reported that the program had been completed and was ready for the printer.

Public Relations: Mrs. Don A. Epler,

Chairman, advised that the program of the Public Relations Committee will appear in the Year Book. Mrs. Epler also presented the methods of procedure for the various projects as suggested by the Advisory Committee. The Editor of the *Journal* is very anxious to have the Public Relations Committees of the various counties let us know how the projects are carried on and promises adequate space.

Revisions: Mrs. F. A. Kinch, Chairman, presented a recommendation that the officers be elected at the Annual Meeting but that they not take office until June 30. This recommendation will be considered at the January meeting.

REPORTS OF COUNTY PRESIDENTS

Reports were submitted by the Presidents of the following counties:

Atlantic—Mrs. Morton Major
Bergen—Mrs. Howard M. Meyer
Burlington—Mrs. E. H. Wyman
Camden—Mrs. George B. German
Hudson—Mrs. A. C. Ruoff
Mercer—Mrs. G. N. J. Sommer
Middlesex—Mrs. Samuel Breslow
Passaic—Mrs. Alfred D. Meneve
Union—Mrs. George Knauer

Mrs. Ulmer moved that we make no allotment for a donation to the New Jersey Social Hygiene Association at this time but that the sum donated last year be put in the Contingent Fund. Seconded and carried.

RESOLUTIONS

Mrs. H. V. Hubbard, Chairman, presented the following resolutions:

It is hereby resolved, by the members of the Woman's Auxiliary to The Medical Society of New Jersey here assembled, that we express our thanks to Mrs. George German, President of the Camden Auxiliary, and to Mrs. Robert Gamon, Chairman

of Hospitality, for their work in arranging for our comfort and enjoyment during this Fall meeting on October 13, 1941; also an expression of our appreciation of the coöperation of the Walt Whitman Hotel.

Mrs. Hubbard moved the adoption of this resolution. Seconded and carried.

It is hereby resolved, that the members of the Woman's Auxiliary to The Medical Society of New Jersey hereby express our thanks to Dr. Thomas K. Lewis, President of The Medical Society of New Jersey, for his coöperation and help to us in carrying on the work of this Auxiliary and for his address today.

Mrs. Hubbard moved the adoption of this resolution. Seconded and carried.

It is hereby resolved that the members of the Woman's Auxiliary to The Medical Society of New Jersey express our thanks to the officers, chairmen and members who have shown their interest in the work and welfare of this Auxiliary by their presence at this Fall meeting on October 13, 1941.

Mrs. Hubbard moved the adoption of this resolution. Seconded and carried.

It is hereby resolved, that the members of the Woman's Auxiliary to The Medical Society of New Jersey express our thanks to Dr. Dodd, Chairman of our Advisory Committee, for his work and coöperation in helping us to carry on the work of this Auxiliary and for his address to us today.

Mrs. Hubbard moved the adoption of this resolution. Seconded and carried.

Mrs. A. W. Pigott, Credentials Chairman, reported a total of 57 members and guests present.

Respectfully submitted,
MRS. BANKS S. BAKER,
Recording Secretary.

Atlantic County

Mrs. Louis Feinstein, Chairman of Press and Publicity

The regular meeting of the *Woman's Auxiliary to the Atlantic County Medical Society* met at the Traymore Hotel November 14, 1941, with Mrs. Morton Major presiding. Routine reports were given by the chairmen of committees. Mrs. Gorson announced that 410 tickets are out for the Sweepstake Dance to be held Saturday evening, December 6, 1941, at the Traymore Hotel. Mrs. James H. Mason reported on the Red Cross Sewing Group, which meets at the Presbyterian Church every Monday. To date 25 diapers have been sewn. Mrs. Mason also introduced the guest speaker of the evening,

Mr. Leon Leonard, newly elected Assemblyman, who spoke on legislation. He explained the mechanics of legislation and also cited several medical bills introduced into the legislature of this state.

Bergen County

Mrs. Parker A. Groff, Chairman of Press and Publicity

The Auxiliary joined the Bergen County Medical Society at their Third Annual Banquet and Dinner Dance, which was held at the Swiss Chalet, November 12. The speaker of the evening was Mr. James Ellenwood, authority on child guidance and family relationships. He was introduced by Dr. H.

W. Wilson, President of the Bergen County Medical Society.

Dancing followed the dinner.

Essex County

By Mrs. Frank S. Forte, Chairman of Publicity

One hundred members attended the opening luncheon meeting of the *Woman's Auxiliary to the Essex County Medical Society* on Monday, October 27, at Bamberger's in Newark.

The Executive Board met at noon, luncheon followed at 1:30 p. m. and then the regular meeting, with Mrs. Edward W. Sprague, the President, presiding. Mrs. Sprague greeted the members and introduced the guest speakers.

Dr. Francis Weber, President of the Essex County Medical Society, commended the Auxiliary for its readiness to help.

Dr. Edward W. Sprague, President of the Academy of Medicine, spoke of efforts by The Medical Society of New Jersey to establish a service plan for patients in the lower income brackets.

Mrs. Frank Bien of Irvington, Program Chairman, introduced Mrs. Charles J. Beck of Mountain Lakes, Chairman of Literature and Drama of the State Federation of Women's Clubs. Mrs. Beck spoke on "What Is America Reading?"

Membership Chairman Mrs. Clymont McArthur proposed Mrs. George F. Stoll, 23 Newman Avenue, Nutley, who was favorably accepted.

Mrs. George A. Scheller, Chairman of Widows and Orphans, spoke of the good work being done by the Society.

Mrs. Sidney Keller and her Social Committee acted as hostesses at the formal opening of the "Eagleton Medical Civic House" of the Academy of Medicine, 91 Lincoln Park. Members of the Auxiliary supervised the furnishing of two rooms.

Gloucester County

Reported by Mrs. Clarence A. Bowersox, Public Relations, Press and Publicity Chairman

The *Woman's Auxiliary to the Gloucester County Medical Society* held a luncheon and business meeting on Friday, October 24, at the home of Mrs. Herman Wright in Pitman, with Mrs. Paul M. Pegau, the President, presiding. There were twenty-three members present. Five new members welcomed were: Mrs. William Chalfonte, Pitman; Mrs. Benjamin Broselow, Clayton; Mrs. Sidney Lintz, Swedesboro; Mrs. Paul Burkett and Mrs. Harry Nelson of Woodbury.

Mercer County

Mrs. Albert F. Moriconi, Chairman, Press and Publicity

The regular monthly meeting of the *Woman's Auxiliary to the Mercer County Medical Society* was held Monday, November 8, 1941, at the F. W. Donnelly Memorial Hospital, Mrs. G. N. J. Sommer, President, presiding.

Mrs. D. Leo Haggerty, Chairman of the Public Relations Committee, mentioned the available sources for speakers and movies which can be utilized when needed at Parent-Teachers Associations, Women's Clubs, etc.

Mrs. Glenn Booz of the Trenton Local Defense Council gave an interesting address on the functions of this organization.

The plan submitted by the National Executive Board of the Auxiliary for the establishment of a central office in Chicago, with a paid secretary, was approved. The ways and means for the maintenance of the office are to be considered later.

Tea was served and an inspection of the hospital's recent renovations followed. The meeting was adjourned at 3:30 p. m.

Passaic County

Mrs. Joseph E. Mott, Chairman, Press and Publicity

At the regular meeting of the *Woman's Auxiliary to the Passaic County Medical Society* held on October 20th, the following resolutions were drawn up by the committee, consisting of Mrs. Catherine Neer, Mrs. Louise Wilkinson and Mrs. Amelia Dwyer:

Whereas, The Woman's Auxiliary to the Passaic County Medical Society was shocked and grieved to learn of the untimely death of Mrs. Louise Weiss Tuers, wife of Dr. G. E. Tuers of Paterson, N. J., on September 19, 1941, it is fitting that we reverence her memory.

The Woman's Auxiliary feel that she will be sorely missed by all associated with the society. Mrs. Tuers was the first President of the Auxiliary. All credit for its existence and growth is due to her early inspiration and continued interest.

To know her was a privilege. She had a fine aptitude for friendship. Her friends were legion. She will ever be remembered as a devoted wife, loving mother, and true friend. "None knew her but to love her, none named her but to praise."

Therefore, be it resolved, That the members of the Woman's Auxiliary to the Passaic County Medical Society extend their sincere sympathy to Dr. Tuers and his daughters.

Be it further resolved, that this resolution be spread in full upon the minutes of the meeting, and that a suitable copy be sent to the family of Mrs. G. E. Tuers.

Union County

Mrs. Rowland P. Blythe, Reporter

Mrs. William C. Meineke Jr. of Roselle was named Chairman of a Supper Dance to be held on Tuesday, December 16th, at "The Brook" in Summit, at the regular meeting of the *Woman's Auxiliary to the Union County Medical Society* held on the evening of November 12th at St. Elizabeth Hospital in Elizabeth. Proceeds of the dance will be used as a fund for the purchasing of a home for indigent physicians of New Jersey.

The President, Mrs. George Knauer of Elizabeth, presided. Mrs. Knauer asked for volunteers willing to assist at the registration desks maintained at the Elizabeth General Hospital and the Elks' Club for the Fourth Fall Clinical Conference to be held on December 3rd at Elizabeth.

Following the meeting, travel motion pictures of Nassau, B. W. I., were shown by Mrs. H. V. Hubbard of Plainfield, and refreshments were served.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

Vol. XIV

December, 1941

No. 12

THE habit of calm appraisal, characteristic of English physicians, seems not to be ruffled by the pressure of war emergencies nor by howling bombs. Tuberculosis work in England, though sometimes interrupted, continues to engage the earnest attention of physicians and laymen. American readers will profit by the clear analysis of S. Vere Pearson of the objects of collapse therapy in the treatment of pulmonary tuberculosis outlined in an address, "What Are We Aiming At in Collapse Therapy?", here condensed for the busy reader.

AIMS OF COLLAPSE THERAPY

The objects of treatment in pulmonary tuberculosis are fourfold: (1) to arrest the progress of the disease, (2) to heal the damaged tissues, (3) to restore the general health and working capacity of the patient, (4) to render him or her sputum negative. Often there is likelihood of clash between these objects and what to do is sometimes overshadowed by the question when to do it. The aims of collapse treatment for pulmonary tuberculosis may be surveyed under eight heads.

1. *The constitutional effects of this disease are of more importance than the local.* The constitutional symptoms, rather than damage to the lungs, endanger life and health. But the successful treatment of the local lesion is the way to allay the constitutional symptoms. The characteristic feature of the disease, a series of reactions in the connective tissues, only secondarily affects the functions of the breathing apparatus. It is the exudative lesions which produce the most dangerous symptoms and while we have yet to learn how the effects of collapse therapy work on them, it is these lesions which are most amenable to collapse therapy.

2. *Its chief characteristic is that it produces reactions in the connective tissues.* Aside from its effect on gross lesions, including cavities, collapse therapy produces ischemia, passive hyperemia and lymphatic stasis which encourage proliferation of connective tissues and the production of fibrosis in early lesions. It is well to emphasize this because too often collapse therapy is reserved for the patient with excavation and other gross lesions. The relaxation, the ischemia and the lymphatic stasis affect the diseased parts more than the healthy.

But the work of healthy lung tissues is eased because the function of the latter is interfered with less than it was, if the toxemia be lessened.

3. *Tubercle bacillus is master of the ceremonies nearly always.* It is a mistake to be apprehensive of secondary organisms within the lesions in the lung, for it is the tubercle bacillus which is the master of ceremonies. It is time the boggy of mixed infection was laid to rest. Only the tubercle bacillus is responsible not only for early infiltration of the Assman type (early round foci) or early excavation, but also for liquefaction.

4. *A re-expanded, healed lung should be our aim whenever and as far as ever possible.* This means that a reversible and temporary type of collapse is to be preferred whenever possible.

5. *The best induced collapse is always a selective one.* So-called "respiratory traumatism" (abnormal stretching of diseased parts) is based on the idea that the movements of respiration do harm to a diseased lung and that collapse treatment counteracts this harm by resting the lung. But on occasion collapse treatment may increase the harm, as for example when a stretched pleural adhesion attached viscally to the region of a cavity in the lung occurs in an artificial pneumothorax. It must ever be an aim of collapse therapy to amend and convert such a condition. The mechanisms which produce harm are those which increase the stretching of diseased parts. These we must discover with the aid of roentgenograms and, even more, by careful observations, on the screen, of respiratory movements. (Slow motion cinematography is being increasingly employed, says the author, to study respiratory movements.)

6. *It is obtained by relaxing tension of diseased parts.* This has long been emphasized but even now, when studying movements, during breathing and coughing too much attention is often given to cavities rather than to the influence of such movements upon the relaxation of other pulmonary tissues.

The movements of respiration affect the diseased parts of the lung either directly or indirectly—a distinction not always easy to make. The surrounding parts can be pulmonary or non-pulmonary and their effect upon the tensions within the thorax must be considered. Collapse therapy aims at relieving these and permitting relaxation. Perhaps even more important than expansion, contraction and movement of cavities is the effect of respiratory movements on the lung tissues surrounding and in proximity to a cavity.

7. *In dealing with cavities our aim is, of course, to get rid of them. Collapse plays a part in this by:*

- a. Closing the broncho-cavernous passage;
- b. Stabilizing and reducing intra-cavitary pressures;
- c. Starving and debilitating the tubercle bacilli on the cavity walls.

"It always strikes me," says the author, "that the hole in the lung has held far too much of the attention." Efforts to classify cavities have been useful but not inconclusive. We are often in doubt today as to the interpretation of an annular shadow. Mistakes are still made between a ring of fibrosis, a zone of reaction around a central focus and one of atelectasis. Even the supposed hole may be found to be no hole on post-mortem examination. There are other difficulties. Probably the best classification of cavities is that of Coryllos; open, closed and narrowed.

Early cavities disappear sometimes without any measure to relax anything. When a cavity does not close spontaneously, collapse therapy is used. Artificial pneumothorax would succeed more frequently if the suitable case was found earlier and proceeded with, especially if cauterization of adhesions were more popular. The excavated lung needs relaxation from without, by detaching it from the bony cage of the thorax, but air under too high a pressure within the cavity itself can keep the hole open, and if such air be absorbed and the compressed lung around the cavity re-expands it will fill the gap. This process is accomplished by getting the bronchial opening blocked and may

occur more or less by accident. Cavity closure after an ineffectual pneumothorax occurs fairly frequently and can be aided by a temporary phrenic operation, but the reason why the cavity closes cannot be explained. Closure may come about through a kinking of the bronchus draining the cavity though a case has been published in which a kinking had a disastrous effect. Our aim should be to know when a kinking has occurred, when it is benefiting the patient and how it has come about. We are far from this knowledge as a rule but able to form an opinion much more often than formerly.

There are several lessons which can be learned for collapse therapy from work in connection with Monaldi's method, namely, the trans-pleural decompression treatment of cavities. One of these has to do with the blocking of the cavity. When a cavity becomes blocked the oxygen is absorbed and the tubercle bacilli languish. There is good evidence to show that an aim of treatment should be to starve and debilitate the tubercle bacilli on the walls of the cavities. When that has been achieved it remains for means to be found to allow the pericavernous tissues, either by expansion or indirectly by their contractile powers, to close the cavity.

8. *The prevention of the discharge of the bacilli.* Cavities are the main, if not the only source of the expectorated positive sputum, augmenting the danger of bronchogenic spread and spread to other persons. An important aim of treatment, therefore, is to prevent the discharge of tubercle bacilli. But the restoration of health must come first; a well-trained ex-patient who behaves sensibly is not a danger. The restoration of the patient to work must not be forgotten in the desire to eliminate cavities and positive sputum.

Finally, our aims should always be based upon clinical and x-ray observations which should not be directed too exclusively to cavities nor to the lung condition. Collapse therapy is not purely mechanical. The many factors of the situation must be taken into account. Our knowledge of collapse treatment is advancing quickly and modifying our practice. That is the ever fascinating interest of medicine. As it progresses certain problems are solved, discussion about them ceases, but new ones arise.

What Are We Aiming At in Collapse Therapy? by S. Vere Pearson, M.D., *Tubercle*, July, 1941.

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HOW TO USE THIS INDEX

This is a single alphabetical index. When searching for an original article, look under the first significant word in the title. Authors are also listed alphabetically, with an asterisk (*) to indicate if reference is to an original article. Editorials are indexed by first significant word of title or by subject, book reviews by title or subject but not by author. City of residence is indicated for authors of original articles.

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The Official List of Members and Fellows, as well as the history of The Medical Society of New Jersey, will be found as the supplement to the April issue. The rules and regulations of the Medical Service Administration are printed in a Supplement to the February number, and the Transactions of the Annual Meeting appear as a supplement to the August issue.

A special index to the Transactions will be found on the first page of the Transactions supplement. The annual reports of the committees and officers of the Society are indexed on page 211 of the May *Journal*.

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- * Original Article
- † Obituary
- e Editorial
- br—Book Review
- ab—Abstract

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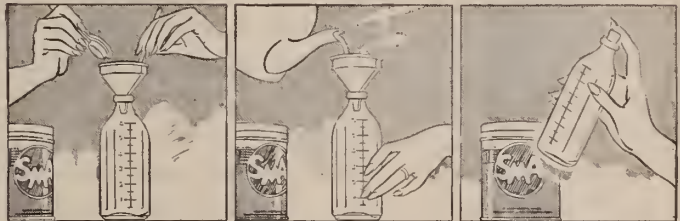
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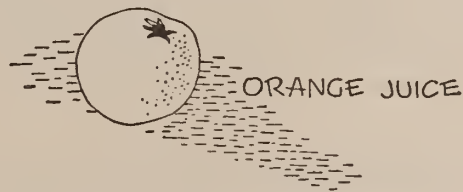
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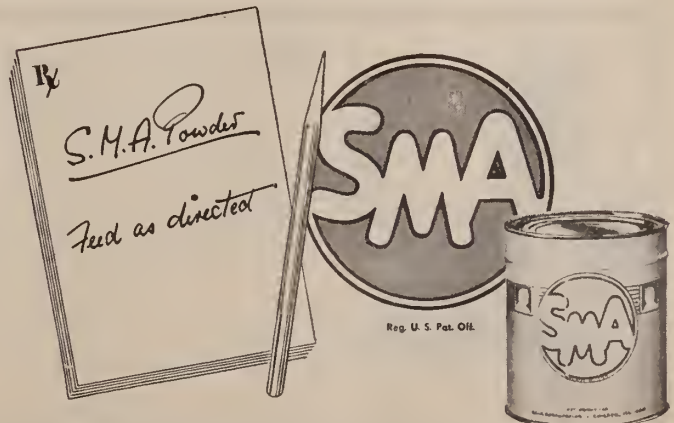
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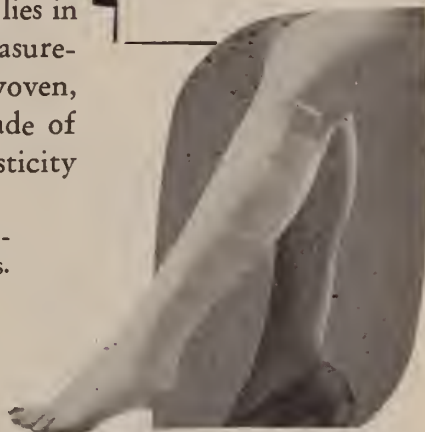
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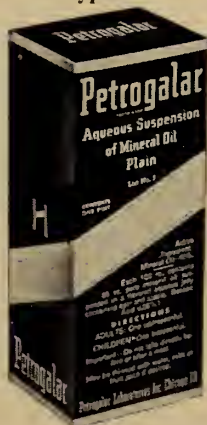
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of the

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of

The Medical Society of New Jersey

On March 15, 1941



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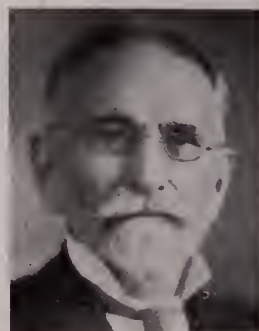
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1766 — 1941

THE MEDICAL SOCIETY of NEW JERSEY

ONE warm June day in 1766, the couriers, as usual, picked up their bundles of the "*New York Mercury*" at the wharf in Elizabethport. They galloped through East Jersey, leaving the "*Mercury*" at taverns and public houses and at the homes of the subscribers, in Paulus Hook and Communipaw, Newark and Perth Amboy, Elizabeth and Springfield. Tucked in a corner of an inside page of the June 27 "*Mercury*" was a notice of interest to physicians.

Who were the physicians? Some were British-educated doctors of medicine; many were products of the 18th century apprenticeship system; some had taught themselves by reading Quence's *Dispensatory*, Fuller *On Fevers* or John Dickinson's monograph on "*That Terrible Disease Vulgarly Called the Throat Distemper*". They had then set themselves up as medicine-men, barber surgeons, or even "male midwives". Many of the doctors were clergymen, for in those days, gentlemen interested in human welfare were often educated for both professions.

The notice which caught their attention read simply: "A large body of the practitioners in physic and surgery in East New Jersey, having agreed to form a society for the advancement of their profession and the promotion of public good, hereby request and invite every gentleman of the profession in the province to attend a meeting at Mr. Duff's Tavern in the City of New Brunswick on Wednesday, July 23, at which time and place, the Constitution and Regulations of the Society are to be settled and subscribed."

So was born the first medical society of the New World. For in the chronologic roll call of American medical organizations, New Jersey's name leads all the rest. How many eligible doctors there were in the province, no one knew. Only sixteen appeared at Duff's Tavern that Wednesday night. An "instrument of association" was adopted and signed by fourteen of the doctors. Here they are, the founders of our Society: William Adams of New Brunswick; Moses Bloomfield of Woodbridge; Berne

Budd of Morristown; William Burnet of Newark; John Cochran of New Brunswick; Lawrence Vanderveer of Millstone; Jonathan Dayton of Springfield; James Gilliland, address unknown; John Griffith of Rahway; Isaac Harris of Piscataway; Christopher Manlove, address unknown; Robert McKean of Perth Amboy. Joseph Sackett of Paramus and Thomas Wiggins of Princeton. Dr. McKean was elected President.

EIGHTEENTH CENTURY ECONOMICS

The first business of the Society was the adoption of a fee schedule. Translating the shillings and pence of pre-Revolutionary America into modern currency, it appears that our 18th century predecessors had a proper estimate of the dignity of their calling. (This was a time, when Governor Franklin's annual salary was about \$3,000, and the best house in Perth Amboy could be rented for less than \$200 a year.) Fee for visits in town was set at \$2.50 a week. For the "opinion of a consulting physician" the patient paid \$4.00. And while a phlebotomy cost only 37 cents, "drawing off urine by catheter" was worth \$1.75 a treatment. "Dressing of a phagedeme ulcer" merited 50 cents per ulcer, according to the schedule. The "administration of a clyster" (enema) was \$1.00, and for "cathartics" the New Jersey doctor received 50 cents a dose. Surgical procedures commanded correspondingly larger fees. Charge for amputating a breast was \$15, and for cutting for stone in the bladder, \$25. The "male midwife" was held to a simple schedule, "Delivering in a natural case, \$7.50; in a preternatural case, \$15." Your broken clavicle could be reduced and dressed for \$7.50. One line in the fee table reads "Gonorrhea, simple, treatment and medicine: \$10.00; Gonorrhea attended with chancre, \$15." For castration, the fee was \$15 a testicle. Tinctures, any kind, were sold at 75 cents an ounce.

No sooner was the fee schedule proposed, when "some evil-minded persons threw an odium on the proceedings, tending to prejudice

the minds of the inhabitants against so laudable an institution as the New Jersey Medical Society". It is not recorded, that the provincial government charged the Society with "restraint of trade"; but it does appear that there was some disapproval of a pounds-shillings-and-pence scale for the relief of human suffering. At any rate, the Society's formal endorsement of the fee schedule was held up until 1784.

THE AGE OF PRECEPTORS

From its first meeting, the Society showed concern about scientific knowledge and medical education. The first scientific address was delivered by Dr. William Burnet of Newark, who in 1767 addressed the organization (in Latin!) on "The Use of the Lancet in Pleurisy". Subsequent addresses included two by Dr. John Cochran of New Brunswick, one on "Putrefaction" and one on the "Catamenia".

As early as 1767, the New Jersey Medical Society exhibited an interest in medical education. There were no medical schools in the province, and apprenticeship was the only local route to medical training. To place the preceptor system on a standardized basis, the Society adopted a rule that "No student be taken as apprentice unless he has competent knowledge of Latin and some initiation in Greek. No member shall take an apprentice for less than four years, the fee to be one hundred pounds a year." An old indenture, giving the wording of the apprenticeship contract, is still on record. It gives some advice to medical students well worth heeding today. Here it is, in part: "Jacobus Hubbard, with the consent of his father and mother, puts himself as an apprentice, unto William Clark of Freehold * * * he shall serve his master well; and faithfully keep his secrets, gladly obeying his lawful commands. The apprentice shall not contract matrimony during the term. At cards and dice he shall not play, nor will he haunt ale houses, taverns or play houses. The master will provide the apprentice with sufficient meat, drink, washing, lodging and mending."

In its 18th century period, members paid 15 shillings (about \$4) a year dues. Most of the Society's income came from fees for examining candidates for medical practice.

THE DOCTOR AS A CITIZEN

Students of colonial history are repeatedly impressed with the civic and communal importance of the physician. Unlike his 20th century successor, he was usually vitally interested in the political and civic affairs of his community. Of the first 100 members of the New Jersey Medical Society, seventeen were mem-

bers of Congress or the Legislature, seven were ministers of the gospel, five were sheriffs, four were judges, and one—Thomas Cadwalader—was the first Burgess (mayor) of Trenton.

At its third meeting, in 1768, the Society petitioned the assembly to enact legislation regulating medical practice. With petition forms stuffed into their saddle bags, doctors circulated among their friends and patients, bombarding the legislators with so many signed demands for the regulation of medical practice that on September 26, 1772, the Provincial Legislature passed its first law on the subject. Under this statute, applicants for a license were examined by a justice of the Supreme Court, who "had the right to call two physicians to his assistance". Shortly after the Revolution, the Supreme Court turned over to the Medical Society the authority to examine candidates and issue licenses.

THE SOCIETY AND THE REVOLUTION

The American Revolution divided the medical profession. Most doctors were rebels, a few were loyalists, but all in the tradition of Hippocrates, labored during the war to alleviate the sufferings of soldiers on either side of the line. New Jersey was the cockpit of the Revolution, sandwiched between the rebel capital at Philadelphia and the Tory stronghold at New York. William Burnet, the Society's second president, and John Cochran, its third president, were the Surgeons-General of the Eastern and Middle Departments of George Washington's Army. At least one of the Society's officers, Dr. Nathaniel Scudder, was known to have been killed in action. There was, of course, no time for scientific or business meetings between the outbreak of the war in 1776 and the establishment of peace in 1781. Cornwallis surrendered on October 19, 1781. A month later, the Medical Society had resumed its meetings.

In 1784, the half-forgotten fee table was revived, its figures translated into the new United States Currency, and a special committee appointed to tell the public why it was in their interest to have such a schedule. This was the germ of the Public Relations program which today is so vital to any medical organization. The preamble to the fee schedule sounds modern in content, if not in wording. It reads: "Apprehending that doctors of medicine have separated themselves to a profession that not only deprives them of many comforts and indulgences by being at the call of any one day and night, but also exposes them to many disagreeable scenes and great dangers; and besides the expense of education and the painful years

in preparatory studies, they are entitled to a just and equitable reward for their services."

As evidence of their public-mindedness, the Society made it clear that the recommended fees were maxima, not minima, and that "every member is at liberty to abate what part of such bills he may think proper on account of poverty, friendship or other laudable motives".

After the Revolution, the Society met twice a year; a "southern" meeting was held in November in Burlington; and a "northern" meeting in May in Princeton or New Brunswick. A charter and seal were granted in 1790. The seal is still in use, though the charter has been revised several times. The name of the organization has undergone some minor but confusing transformations. The organizers at Mr. Duff's Tavern called it the "The New Jersey Medical Society". In the 1790 charter the name was "The Medical Society of New Jersey", which in 1816 was changed to "Medical Society of the State of New Jersey". Then to memorialize the fact that our Society is older than our State, the name was returned to "The Medical Society of New Jersey" in 1818: and has remained so to this day.

A RIVAL SOCIETY

In 1790 a "rebellious" member appeared to disturb the peace of the Society. He was Paul Micheau, who moving across the Kill from Staten Island to Elizabethtown, opened a one-man medical school. He gave one lecture a day for two months, charged \$25.00 tuition, and sought to qualify his graduates as doctors of medicine. Meeting the resistance of the Medical Society, he began to agitate for a rival organization. He pointed out that most of the doctors lived in the northeastern corner of the state, and that it was unfair to ask the bulk of the profession to drive all the way to Princeton every May; while the two-day ride to Burlington in the November mud was certainly an injustice to physicians living in Essex and Bergen Counties (which included present Union and Hudson Counties, too)! He succeeded in forming a "Medical Society of the Eastern District of New Jersey" which for fifteen years successfully competed with the senior organization. Micheau's society met quarterly instead of semi-annually. Its meetings were held in Elizabeth or Newark and were generally livened by dramatic presentations which the older Society, meeting less often, and at a less accessible place, could not match. By 1807, however, peace was restored, and the New Jersey profession was once more united—and has remained so ever since.

Micheau was not the only medical school proprietor in New Jersey. Two years after he had established the Elizabethtown school, Dr. Nicholas Romaine persuaded Queens College (now Rutgers) to allow him to open a school in New Brunswick under its charter. This school was patronized largely by New York medical students, and when the New York Legislature, in 1811, refused to license its graduates it closed its doors.

In 1819, the Medical Society took part in the establishment of the first United States Pharmacopeia. It sent two delegates—Dr. John Van Cleve of Princeton and Dr. Charles Smith of New Brunswick—to the first U. S. P. convention in Philadelphia, and it has always co-operated in the periodic revisions of the pharmacopeia.

FORMATION OF COUNTY SOCIETIES

In 1816 a new charter was granted. The lesson of Micheau's rival organization had not been forgotten, and to discourage independent local societies, by making attendance at meetings more convenient, the chartering of district or county societies was permitted. Societies were at once formed in Somerset, Essex, Middlesex, Monmouth and Morris. For a short time, doctors were obliged to "join" two organizations—their district (county) society and The Medical Society of New Jersey. In 1818, the structure of the state organization was altered, so that it became (as it is now) a league of county societies. A doctor thus joined his local society while the local societies, through delegations, made up the state organization. The Medical Society of New Jersey received the power to license and examine applicants for practice, actual examinations being conducted by "censors" appointed for each county. In 1825 the "Fellowship" status was created and awarded to Past Presidents. In the same year, the Society was granted the right to confer the M.D. degree. The Medical Society of New Jersey thus was, and to this day still is, the only agency in New Jersey that may confer the M.D. degree.

Between meetings, the affairs of the Society were managed by a "Standing Committee" of three members. This hard-working triumvirate was simultaneously a Board of Trustees, a judicial council, a welfare committee and an executive officer. The "Standing Committee" was to remain standing for eighty years—until the increasing complexity of the organization's affairs made necessary a less primitive executive unit.

FIRST PUBLIC HEALTH ACTIVITIES

In 1837, Dr. Lyndon Smith of Newark began stressing the need for a state hospital for the mentally ill. He and Dr. Condit were appointed by the Legislature to survey the problem, and on the basis of the Society's report, the Legislature in 1846 appropriated the funds for the state's first mental hospital. This institution, built at Trenton in 1848, was one of the first psychiatric hospitals in the country.

The Medical Society of New Jersey, always sensitive to public health problems, adopted a resolution on November 9, 1847, urging sextons to report all baptisms and funerals to the Society for the compilation of vital statistics. A year later, the Society persuaded the State to assume this function, and the enactment of New Jersey's first Birth and Death Registration Law sowed the seed out of which our state Health Department was to sprout.

ESTABLISHING THE A. M. A.

In 1845, the Society received from the New York State Medical Society an invitation to join with several other state organizations to consider forming a nationwide body of physicians. While it accepted the invitation, The Medical Society of New Jersey failed to appoint representatives. At a meeting held in New York in 1846, two of our members, Dr. Lyndon Smith and Dr. E. J. Marsh—the former a past-president, the latter a member of the Standing Committee—were present as unofficial observers. They were invited to participate in the deliberations of the group, which culminated in the issuing of a call for a general meeting in Philadelphia in May, 1847. All medical schools and state societies were invited to send delegates to this session. New Jersey's representatives were Drs. L. A. Smith, E. J. Marsh, F. S. Schenck, William Pierson, I. Garrison, J. Parrish, O. H. Taylor, R. M. Cooper, Quinton Gibbon and Zachariah Read. At this meeting, the American Medical Association was founded. Incidentally, the delegation's entire expense account for the Philadelphia trip was \$45.54!

FIRST MEDICAL PUBLICATION

The following year saw New Jersey's first medical magazine—the "*New Jersey Medical Reporter*". It was published quarterly by Dr. Samuel Parrish of Burlington, and was made the official medium for publication of the Society's activities. When it moved out of New Jersey in 1850, the Society established its own publication, the "*Transactions*". This was published for forty-four years, to be succeeded in

1903 by "*The Journal of The Medical Society of New Jersey*".

As medical schools improved, the apprenticeship system withered; this development, combined with increasing legislative concern with medical practice, made it possible for the Society to relinquish its rôle as examiner of applicants for licensure; and in 1866, the Society, retaining the power to confer the M.D. degree, transferred to the State the right of licensing candidates. In 1890, the complete disappearance of the apprenticeship system was symbolized by the establishment of the State Board of Medical Examiners.

Dr. Ezra Hunt of Metuchen, distinguished member of the Society, had, since the Civil War, been urging the creation of a State Health Department. Stimulated by the Medical Society, the Legislature finally set up this Department, by legislation enacted in 1877.

CERTIFIED MILK

On December 5, 1892, before the Practitioner's Club of Newark, Dr. Henry L. Coit of Newark, N. J., outlined a plan for the production of "Certified Milk". This original plan included chemical, bacteriologic and veterinary standards, medical supervision of dairy hygiene and health of employees. These objects were to be obtained by means of a rigid contract between the dairyman and the commission composed of physicians to be known as the Essex County Medical Milk Commission. Thus was established the original certified milk; it was acclaimed throughout the world.

ESTABLISHMENT OF BOARD OF TRUSTEES

In 1903, the structure of the Society was modernized. The old Standing Committee was succeeded by a Board of Trustees; the "*Journal*" was established. In 1920, the present Welfare Committee was organized, with its four major subcommittees. Since then the rapid growth of committees, with their increasing responsibility, has brought the Society to the healthy situation of having a fifth of its members on state committees. Since most of the work of the Society is done in and through committees, this widespread rank-and-file participation has made New Jersey's Society one of the most democratic, yet effective professional organizations in the country.

MEDICAL LEGISLATION

Today, as in 1766, The Medical Society of New Jersey has an intimate interest in legislation that will assure high medical standards for our state. The simple Act of September 26, 1772, was passed by the provincial Legislature

to protect the Colony against 18th century panacea peddlars. As already related, the Legislature was activated into establishing these regulations by the young Medical Society whose members busied themselves collecting petitions urging enactment. In 1941, the Medical Society is still vigorously battling to protect citizens from fractionally educated healers. The current Uniform Medical Practice Act, generally considered a model of its kind, was warmly supported by the Society. All efforts to depreciate educational requirements, lower the barriers against quackery, or scuttle our present high health criteria are resisted by the Medical Society. Legislators look on the Society as a watchdog of medical standards; the press has come to see the organization as an agency for the intelligent, unbiased analysis of proposed changes in health legislation.

ADVISORY COMMITTEES

Through a battery of advisory committees, The Medical Society of New Jersey labors effectively for the reduction of morbidity and mortality rates. A pioneer Maternal Welfare Committee has initiated a concrete program that has reduced New Jersey's maternal mortality by more than fifty per cent. This it has done through public education, elevation of hospital standards, standardization of reporting and analysis techniques, and specialized instruction to doctors. A Child Health Committee has made it possible for the press to describe New Jersey as "one of the country's safest states for babies". Again, through media like public education, baby keep-well stations, special studies of the premature baby, instruction of doctors, and the like, the committee has dynamically met its problems and has seen New Jersey repeatedly win the blue ribbon for low infant mortality. A Pneumonia Control Committee has made it possible for indigent patients to receive serum and the newer chemicals that have so dramatically lowered the pneumonia death rate. A Committee on Nursing Education guards training standards and helps give New Jersey hospitals their high status as training institutions for nurses. All aspects of hospital facilities are under the alert attention of a special Hospital Committee. A Committee on Pharmaceutical Problems periodically issues a special formulary of useful, inexpensive medications; a formulary which simplifies the doctor's prescription problem and cases the burden on the patient's pocketbook. Two dozen other advisory committees toil ceaselessly in their special fields.

MEDICAL PREPAREDNESS

In every epidemic, war or other crisis afflicting our state or our nation, The Medical Society of New Jersey has been able energetically to mobilize the medical personnel and medical resources of the state. So it was with the Revolution, to the prosecution of which, the ten-year-old Society contributed many medical officers. So with all such crises. And in 1941, when the problem of national defense was catapulted into public prominence The Medical Society of New Jersey swiftly stepped into the breach. Two hundred selective-service medical boards were promptly manned with Society-recommended doctors. Dozens of advisory bodies, numerous medical appeal boards, and two complete induction panels were nominated by the Medical Society. With an efficiency that won public recognition from military authorities, these boards went to work. Manifestly this huge and complex medical task could never have been accomplished without the existence and labor of a well-organized medical society.

MEDICAL SERVICE ADMINISTRATION

Current symbol of the modernism of our Society is its sponsorship of the Medical Service Administration. For here is a new problem facing an old profession; the problem of distributing many-sided, 20th century medical care to the self-respecting citizen to whom prolonged or catastrophic illness would be a serious financial blow. How to deliver medical services to families in the lower income group without pauperizing them, stripping them of their free choice of physician, or plunging them into bankruptcy, is a problem that Organized Medicine must meet. The Medical Society of New Jersey, after a two-year study of the need, has finally witnessed the Legislature enact, the State Banking and Insurance Commission approve, an administration for the management of voluntary nonprofit health insurance plans, which by their absence of regimentation, compulsion or governmental tampering, are recognized as being thoroughly concordant with our American Way.

THE MEDICAL SOCIETY TODAY

The Medical Society of New Jersey today reflects the complexity of contemporary organized living. It faces its own members; and it gives them the service of a monthly scientific Journal, legal aid in their problems of practice, and a series of special post-graduate courses. It faces the American Medical Asso-

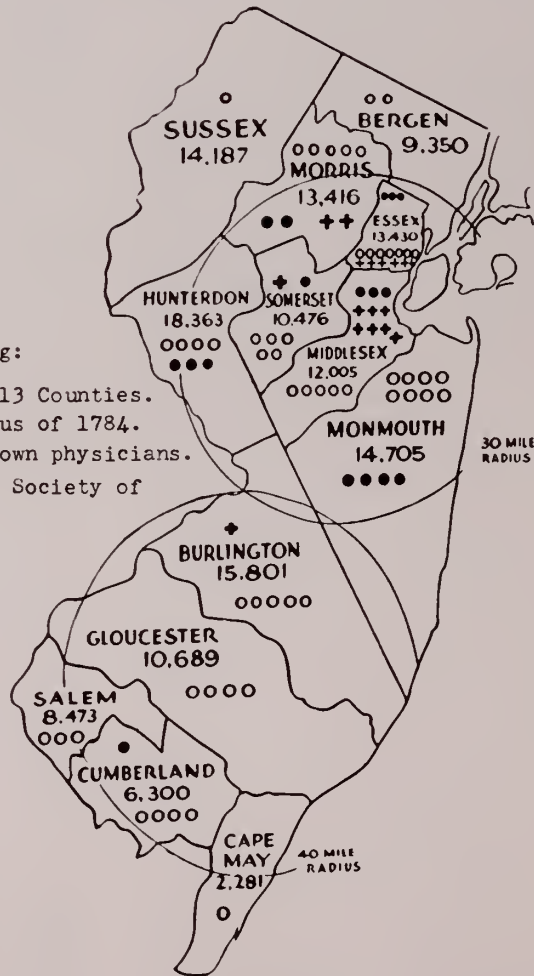
ciation, and gears New Jersey into the complex machine of Organized American Medicine. It faces the Legislature and campaigns for sound public health legislation. It works with related professions—pharmacists, nurses, health officers, dentists, and all groups interested in human welfare. Finally, and perhaps fundamentally, it faces the public. For in the last analysis, the every-day citizen is the source of our privileges, the beneficiary of our labors, the employer of our services, and the judge of our effectiveness. Since our prestige depends on our status in the hearts of the community, it is fitting that the cultivation of sound public relations is a keynote of our modern program.

Rooted in that first effort to show the community that the Medical Society was motivated primarily by genuine interest in public service, our public relations project has flowered until today it encompasses a speakers' bureau, an exhibit service, a well-rounded community-contact program, and a state-wide press coverage of health information.

"Into whatever house I shall enter, I shall go for the benefit of the sick." So it was written two millenia ago. To the preservation of that oath, The Medical Society of New Jersey has dedicated the 175 years of its existence. No more worthy purpose can be conceived; no less worthy one can be considered.

New Jersey in 1766, showing:

1. The boundaries of its 13 Counties.
 2. Their population--census of 1784.
 3. The number of their known physicians.
- + Founder of The Medical Society of New Jersey.
 • Joined later.
 o Non-members.



OFFICIAL LIST
OF
THE FELLOWS, THE HONORARY MEMBERS,
AND THE OFFICERS
OF
THE MEDICAL SOCIETY OF NEW JERSEY
AND
The Officers and the Members of Its Twenty-one
Component County Societies
FOR THE YEAR 1941

1. THE FELLOWS

"THE FELLOWS ARE THE EX-PRESIDENTS OF THE SOCIETY." (Constitution, Art. IV., Sec. 2a)

This list contains:

1. The name of each President, in the order of his service and the year of his election;
2. His residence;
3. The dates of his birth and death;
4. His outstanding characteristics; and
5. The source of information regarding his life.

W—The Volume entitled "History of Medicine and Medical Men of New Jersey" from the settlement of the Province to the year 1800, by Stephen Wickes, M.D., Orange, New Jersey, printed in 1879.

T—The Transactions of The Medical Society of New Jersey, issued annually, 1858-1903.

J—The Journal of The Medical Society of New Jersey, issued monthly since September, 1904.

GR—A Group of portraits of 80 of the 120 past presidents serving from 1766 to 1916, published in The Journal of June, 1916, page 330.

Year of
Election

1. 1766—ROBERT MCKEAN, Perth Amboy, July 13, 1732—Oct. 17, 1767. Pastor and Physician. A Founder of the State Society. W, p. 329.
 2. 1767—WILLIAM BURNET, Newark, Dec. 2, 1730—Oct. 7, 1791. Army Surgeon and Member of Congress. Founder. W, p. 184; GR, No. 1. Photograph hangs in Editorial Office.
 3. 1768—JOHN COCHRAN, New Brunswick, Sept. 1, 1730—Apr. 6, 1807. Hospital Director in Revolution. Founder. W, p. 204; GR, No. 2. Photograph hangs in Editorial Office.
 4. 1770—NATHANIEL SCUDDER, Freehold, May 10, 1733—Oct. 16, 1781. Congressman. Killed in Revolution. W, p. 389.
 5. 1771—ISAAC SMITH, Trenton, 1740—Aug. 29, 1807. Congressman, Judge, Financier. W, p. 398; GR, No. 3. Photograph hangs in Editorial Office.
 6. 1772—JAMES NEWELL, Freehold, 1725—Feb. 21, 1791. M.D. received in Edinburgh. W, p. 341.
 7. 1773—ABSALOM BAINBRIDGE, Lawrenceville, 1742—June 23, 1807. A Loyalist during the Revolution. Large practice in New York City. Father of Commodore Bainbridge. W, p. 131.
 8. 1774—THOMAS WIGGINS, Princeton, 1731—Nov. 14, 1801. Treasurer of College. Founder. W, p. 433.
 9. 1775—HEZEKIAH STITES, Cranbury, 1726—Nov. 17, 1790. W, p. 405.
- No formal meetings 1776-1780 on account of the War of the Revolution.
10. 1781—JAMES NEWELL, No. 6, reelected. Son Elisha was President in 1795.
 11. 1782—JOHN BEATTY, Trenton, Dec. 19, 1749—May 30, 1826. Commissary of prisoners in Revolution. W, p. 138; GR, No. 4.
 12. 1783—THOMAS BARBER, Matawan, died 1807, aged about 80. Surgeon in Revolution. W, p. 133.
 13. 1784—LAWRENCE VANDER VEER, Roycefield, 1740—1815. Last surviving founder of State Society. W, p. 427. Photograph hangs in Editorial Office.
 14. 1785—MOSES BLOOMFIELD, Woodbridge, Dec. 4, 1729—Aug. 14, 1791. Surgeon in Revolution. Founder. W, p. 149.
 15. 1786—WILLIAM BURNET, Newark. President No. 2 in 1767.
 16. 1787—JONATHAN ELMER, Bridgeton, Nov. 29, 1745—Sept. 3, 1817. U. S. Senator and Judge. In first class to receive M.D. degree from U. Pa. W, p. 244.
 17. 1788—JAMES STRATTON, Swedesboro, Aug. 20, 1755—Mar. 29, 1812. Judge. W, p. 410.

18. 1789—MOSES SCOTT, New Brunswick, 1738—Dec. 28, 1821. Director of hospitals in Revolution. W, p. 386; J, 1916, p. 382, and portrait.
19. 1790—JOHN GRIFFITH, Rahway, Nov. 19, 1736—Aug. 23, 1805. Founder. W, p. 270.
20. 1791—LEWIS DUNHAM, New Brunswick, 1754—Aug. 26, 1821. Revolutionary soldier. W, p. 239.
21. 1792—ISAAC HARRIS, Middlesex County, and then Salem, 1741—1808. Taught medical students. Founder. W, p. 275.
22. 1795—ELISHA NEWELL, Allentown, 1755—1799. Son of James, 6th and 10th President. W, p. 342.
No formal meetings for twelve years, owing to an attempt to establish a rival society in Eastern New Jersey.
23. 1807—JONATHAN F. MORRIS, Somerville, Mar. 21, 1760—Apr. 10, 1810. Soldier in the Revolution. Partner of 24th President. W, pp. 338, and 415.
24. 1808—PETER I. STRYKER, Somerville, June 22, 1766—Oct. 19, 1859. President three times. W, p. 414.
25. 1809—LEWIS MORGAN, Rahway, 1757—Jan. 12, 1821. W, p. 336.
26. 1810—LEWIS CONDUCT, Morristown, Mar. 3, 1773—May 26, 1862. Congressman. Trustee Princeton University. W, p. 214; GR, No. 5.
27. 1811—CHARLES SMITH, New Brunswick, 1768—May 7, 1848. Poor boy, but died rich. W, p. 397.
28. 1812—MATTHIAS H. WILLIAMSON, Elizabeth. Meager biography. Served two years. W, p. 435.
29. 1814—SAMUEL FORMAN, Freehold, Aug. 3, 1764—Dec. 11, 1845. Active in practice. T, 1871, p. 84. W, p. 261.
30. 1815—JOHN VAN CLEVE, Princeton, 1778—Dec. 24, 1826. Lectured in medicine in Princeton University. W, p. 425.
31. 1816—LEWIS DUNHAM, President No. 20 in 1791.
32. 1817—PETER I. STRYKER. See No. 24.
33. 1818—JOHN VAN CLEVE. See No. 30.
34. 1819—LEWIS CONDUCT. See No. 26.
35. 1820—JAMES LEE, Newark. Few details. Large practice. Went to Baltimore. T, 1867, p. 129; GR, No. 6. Photograph hangs in Editorial Office.
36. 1821—WILLIAM G. REYNOLDS, Manalapan. A sailor. Had great mechanical skill. T, 1871, p. 78.
37. 1822—AUGUSTUS R. TAYLOR, Somerville, May, 1782—Nov. 10, 1840. Very active. J, 1916, pp. 374, and 500. GR, No. 27.
38. 1823—WILLIAM B. EWING, Greenwich, Dec. 12, 1776—Apr. 23, 1866. Member of Legislature. Judge. T, 1867, p. 207; and T, 1871, p. 170.
39. 1824—PETER I. STRYKER. See Nos. 24 and 32.
40. 1825—GILBERT S. WOODHULL, Manalapan, Jan. 11, 1794—Oct. 13, 1830. T, 1871, p. 79.
41. 1826—WILLIAM D. MCKISSACK, Millstone, 1781—Mar. 6, 1853. Son and father of leading doctors. W, p. 330; GR, No. 8.
42. 1827—ISAAC PIERSON, Orange, Aug. 15, 1770—Sept. 22, 1833. Congressman and Sheriff. His son, No. 84, and his grandson, No. 115, were also Presidents. W, p. 365.
43. 1828—JEPHTHA B. MUNN, Chatham, Dec. 24, 1780—June 22, 1863. Worked on Pharmacopeia. T, 1864, p. 72.
44. 1829—JOHN W. CRAIG, Somerset Co., 1795—Oct. 15, 1871. Member of Legislature. T, 1872, p. 229.
45. 1830—AUGUSTUS R. TAYLOR. See No. 37.
46. 1831—THOMAS YARROW, Sharptown, Salem Co., 1778—1841. Was succeeded in practice by his son, William. GR, No. 9.
47. 1832—E. FITZ RANDOLPH SMITH, New Brunswick, 1786—May 25, 1865. Banker and Mayor. T, 1866, p. 128; GR, No. 10.
48. 1833—WILLIAM FORMAN, Monmouth County, Aug. 17, 1796—Feb. 22, 1848. T, 1871, p. 86.
49. 1834—SAMUEL HAYES, Newark, 1776—July 30, 1829. Charged 25 cents a visit. T, 1867, p. 126.
50. 1835—ABRAHAM P. HAGERMAN, Somerset County. Meager record. (Data requested.)
51. 1836—HENRY VANDER VEER, son of the 13th President, Somerville, 1792—Feb. 13, 1874. Very active. T, 1874, p. 106.
52. 1837—LYNDON A. SMITH, Newark, Nov. 11, 1795—Dec. 15, 1865. Promoted State Insane Asylum. T, 1866, p. 133.
53. 1838—BENJAMIN H. STRATTON, Mt. Holly, Feb. 6, 1804—Dec. 31, 1875. Grandson of Dr. James Stratton, 17th President. W, p. 410; T, 1876, p. 143; GR, No. 11.
54. 1839—JABEZ G. GOBLE, Newark, Nov. 13, 1799—Feb. 7, 1859. "Handshaker." Active in State Society. T, 1867, p. 132.
55. 1840—THOMAS P. STEWART, Hackettstown, June 7, 1798—Oct. 26, 1846. A Founder of Warren County Medical Society, 1826. T, 1890, p. 220. Photograph on file in Editorial Office.
56. 1841—FERDINAND S. SCHENCK, Six Mile Run, Feb. 11, 1790—May 16, 1860. Congressman. Trustee Rutgers University. T, 1861, p. 23; GR, No. 12.
57. 1842—ZACHARIAH READ, Mt. Holly, Sept. 19, 1808—July 28, 1879. A quiet, useful life. T, 1880, p. 124.
58. 1843—ABRAHAM SKULMAN, Bound Brook, Mar. 1796—Dec. 10, 1862. T, 1863, p. 22.
59. 1844—GEORGE R. CHETWOOD, Elizabeth, May 21, 1802—died aged over 80 years. T, 1887, p. 305; GR, No. 13.
60. 1845—ROBERT S. SMITH, Bound Brook, Feb. 19, 1800—Aug. 20, 1874. A devoted physician. T, 1875, pp. 101, and 106; GR, No. 14.
61. 1846—CHARLES HANNAH, Deerfield, Cumberland Co., Nov. 23, 1782—Apr. 20, 1857. GR, No. 15.
62. 1847—JACOB T. B. SKILLMAN, Woodbridge and New Brunswick, Mar. 10, 1794—June 26, 1864. Student of Dr. A. R. Taylor, No. 37. Learned and judicious. T, 1865, p. 72.
63. 1848—SAMUEL HAYES PENNINGTON, Newark, Oct. 16, 1806—Mar. 14, 1900. LL.D. from Princeton. T, 1898, p. 99; T, 1900, p. 186; portrait, T, 1916, p. 286; GR, No. 16.
64. 1849—JOSEPH FITHIAN, Woodbury, June 25, 1795—Jan. 8, 1881. "Courteous, of the old school." T, 1881, p. 160; GR, No. 17.

65. 1850—ELIAS J. MARSH, Paterson, Jan. 7, 1803—Oct. 29, 1850. Delegate to the first organization meeting of the A. M. A. J, 1916, p. 276. Photograph of certificate of examination by censors for license to practice, J, 1937, p. 399; GR, No. 18. Photograph hangs in Editorial Office.
66. 1851—JOHN H. PHILLIPS, Pennington, 1814—Mar. 1, 1878. Founder of State Normal School. T, 1878, p. 204; GR, No. 19.
67. 1852—OTHNEIL H. TAYLOR, Camden, May 4, 1803—Sept. 5, 1869. Active in cholera epidemic. T, 1870, p. 90; portrait frontispiece, T, 1875; GR, No. 20.
68. 1853—SAMUEL LILLY, Lambertville, Oct. 15, 1815—Apr. 3, 1880. Congressman and Judge. T, 1880, p. 118; GR, No. 21.
69. 1854—ALFRED B. DAYTON, Middletown Point, Dec. 25, 1812—July 19, 1870. Medical writer. T, 1871, p. 95; GR, No. 22.
70. 1855—JAMES B. COLEMAN, Trenton, 1806—Dec. 19, 1877. Invented forced ventilation. T, 1878, p. 201; GR, No. 23.
71. 1856—RICHARD M. COOPER, Camden, Aug. 30, 1816—May 24, 1874. Large practice. T, 1874, p. 108; Frontispiece, T, 1874; GR, No. 24. Photograph hangs in Editorial Office.
72. 1857—THOMAS RYERSON, Newton, Feb. 18, 1821—May 27, 1887. Surgeon. Very active. J, 1887, p. 300; GR, No. 25.
73. 1858—ISAAC PIERSON COLEMAN, Pemberton, Feb. 2, 1804—Nov. 4, 1869. Brother of No. 70. T, 1870, p. 93.
74. 1859—JOHN R. SICKLER, Mantua, Sept. 20, 1800—Apr. 11, 1886. Judge. T, 1886, p. 171; Memorial, J, 1919, p. 5; GR, No. 26.
75. 1860—WILLIAM ELMER, Bridgeton, Oct. 5, 1814—July 27, 1889. Third of four generations of doctors. T, 1890, p. 340, and portrait frontispiece; J, 1908, p. 129; GR, No. 27.
76. 1861—JOHN BLANE, Perryville, July 7, 1802—June 18, 1885. Wrote a most excellent history of Hunterdon County Medical Society. T, 1886, p. 147; GR, No. 28.
77. 1862—JOHN WOOLVERTON, Trenton, Oct. 27, 1825—Sept. 14, 1888. Mayor. T, 1889, p. 174; GR, No. 29.
78. 1863—THEODORE R. VARICK, Jersey City, June 24, 1825—Nov. 23, 1887. Manager Morris Plains Hospital for Insane. T, 1888, p. 155, portrait frontispiece; portrait, J, 1916, p. 281; GR, No. 30.
79. 1864—EZRA M. HUNT, Metuchen, Jan. 4, 1830—July 1, 1894. Established State Department of Health T, 1895, p. 206; J, 1916, p. 287; GR, No. 31.
80. 1865—ABRAHAM COLES, Newark, Dec. 26, 1813—May 3, 1891. Poet, and active in practice. T, 1891, p. 235; GR, No. 32.
81. 1866—BENJAMIN R. BATEMAN, Bridgeton, Mar. 7, 1807—July 23, 1883. Meager record. T, 1884, pp. 134 and 163; GR, No. 33.
82. 1867—JOHN C. JOHNSON, Blairstown, Oct. 21, 1828—Dec. 23, 1907. Educator. J, 1908, Feb., p. 365, with portrait; GR, No. 34.
83. 1868—THOMAS J. CORSON, Trenton, Feb. 12, 1828—May 10, 1879. Superintendent of Schools. T, 1879, p. 209; GR, No. 35.
84. 1869—WILLIAM PIERSON, Orange, Dec. 4, 1796—Oct. 1, 1882. Recording Secretary 1835-1866. Son of Isaac Pierson, No. 42. W, p. 365; T, 1883, p. 294; GR, No. 36.
85. 1870—THOMAS F. CULLEN, Camden, Sept. 3, 1822—Nov. 21, 1877. Writer. T, 1878, p. 198; GR, No. 37.
86. 1871—CHARLES HASBROUCK, Hackensack, Apr. 11, 1818—Nov. 25, 1877. Civic leader. T, 1878, p. 199.
87. 1872—FRANKLIN GAUNTT, Burlington, July 19, 1823—July 7, 1900. Supported early bacteriology. T, 1901, p. 294; GR, No. 38.
88. 1873—THOMAS J. THOMASON, Perrineville, 1833—Aug. 20, 1880. Wrote History of Monmouth County Medical Society. T, 1881, p. 162; GR, No. 39.
89. 1874—GEORGE H. LARISON, Lambertville, Jan. 4, 1831—Mar. 7, 1892. Large practice. Local preacher. T, 1892, p. 211, portrait frontispiece; GR, No. 40.
90. 1875—WILLIAM O'GORMAN, Newark, July 12, 1824—Nov. 10, 1887. Founded St. Michael's Hospital. T, 1889, p. 171.
91. 1876—JOHN V. SCHENCK, Camden, 1825—July 25, 1882. Obstetrician. T, 1883, p. 291; GR, No. 41.
92. 1877—HENRY R. BALDWIN, New Brunswick, Sept. 18, 1829—Feb. 3, 1902. L.L.D. Rutgers, 1893. T, 1902, p. 255; GR, No. 42.
93. 1878—JOHN S. COOK, Hackettstown, June 19, 1827—Jan. 1, 1900. A family of country doctors. T, 1900, p. 179; GR, No. 43; Life and Portrait in History of Sussex and Warren Counties, by James P. Snell, p. 520.
94. 1879—ALEXANDER W. ROGERS, Paterson, 1814—May 14, 1905. Delegate to International Congress. J, 1905, June, p. 328; GR, No. 44. Photograph hangs in Editorial Office.
95. 1880—ALEXANDER N. DOUGHERTY, Newark, Jan. 1, 1822—Nov. 28, 1882. Controlled scurvy in Army of the Potomac. T, 1883, p. 299; GR, No. 45.
96. 1881—LEWIS W. OAKLEY, Elizabeth, Nov. 22, 1828—Mar. 3, 1888. Three years in Civil War. T, 1888, p. 163; GR, No. 46.
97. 1882—JOHN W. SNOWDEN, Blackwood, Apr. 22, 1823—May 28, 1888. Obstetrician. T, 1888, p. 167; GR, No. 47.
98. 1883—STEPHEN WICKES, Orange, Mar. 17, 1813—July 8, 1889. The great historian of The Medical Society of New Jersey, and leader of its organization and evolution. T, 1890, p. 335; Portrait, J, 1916, p. 289; GR, No. 48.
99. 1884—PHANETT C. BARKER, Morristown, May 9, 1835—Aug. 21, 1903. Active in public health and hospital work. Obituary in "The Morristown Jerseyman" of Aug. 28, 1903; GR, No. 49.
100. 1885—JOSEPH PARRISH, Burlington, Nov. 11, 1818—Jan. 15, 1891. Established N. J. Reporter, Oct., 1847. Established training school for idiots. Member U. S. Sanitary Commission. T, 1891, p. 243, with portrait; GR, No. 50.
101. 1886—CHARLES J. KIPP, Newark, Oct. 22, 1838—Jan. 13, 1911. Founder Newark Eye and Ear Infirmary 1880, also of Widows and Orphans relief. J, 1911, Feb., p. 486; J, Aug., 1911, p. 135; J, 1924, Feb., p. 70; portrait J, 1916, p. 290; GR, No. 51.

102. 1887—JOHN W. WARD, Trenton, Feb. 12, 1840—Aug. 24, 1916. Superintendent State Hospital, Trenton. J, 1916, pp. 307 and 504 and 506; GR, No. 61.
103. 1888—H. GENET TAYLOR, Camden, July 6, 1837—Jan. 14, 1916. First proposed scientific sections of Annual Meeting, and a State Medical Journal. Son of No. 67. T, 1889, pp. 73 and 74, also J. Sept., 1904, p. 11; J, 1916, pp. 90 and 98; GR, No. 52.
104. 1889—BERIAH A. WATSON, Jersey City, Mar. 26, 1836—Dec. 22, 1892. Civil War Veteran. Writer. T, 1893, p. 186; GR, No. 53.
105. 1890—JAMES S. GREEN, Elizabeth, July 22, 1829—July 2, 1892. Father of No. 141. T, 1893, p. 266; GR, No. 54. Photograph hangs in Editorial Office.
106. 1891—ELIAS J. MARSH, JR., Paterson, Aug. 4, 1835—Aug. 3, 1908. Army Surgeon. Medical Director Mutual Life Ins. Co. Son of No. 65. J, 1908, Sept., p. 194; GR, No. 55; also J, 1937, p. 398. Photograph hangs in Editorial Office.
107. 1892—GEORGE T. WELCH, Passaic, 1845—Aug. 25, 1924. J, 1924, p. 304; GR, No. 62. Photograph hangs in Editorial Office.
108. 1893—JOHN G. RYERSON, Boonton, 1834—Feb. 10, 1916. Popular and practical. J, 1916, pp. 145 and 252; GR, No. 63.
109. 1894—OBADIAH H. SPROUL, Flemington, May 29, 1844—Feb. 13, 1925. Attended every State Society meeting during his medical lifetime. J, 1930, p. 689 with portrait; J, 1937, p. 396, with portrait; GR, No. 64. Photograph hangs in Editorial Office.
110. 1895—WILLIAM ELMER, Trenton, Dec. 14, 1840—July 18, 1908. J, 1908, p. 129 with portrait; GR, No. 56.
111. 1896—THOMAS J. SMITH, Bridgeton, 1841—June 14, 1932. Established Epileptic Colony at Skillman. J, 1932, p. 616; GR, No. 65.
112. 1897—DAVID C. ENGLISH, New Brunswick, Mar. 2, 1842—Sept. 19, 1924. Editor of Journal and Trustee. J, 1924, pp. 325, 336, and 363; GR, No. 66; also J. June, 1937, p. 397, with portrait.
113. 1898—CLAUDIUS R. P. FISHER, Bound Brook, Aug. 12, 1859—June 5, 1927. Civic affairs. J, 1916, p. 293; J, 1927, p. 442; GR, No. 67.
114. 1899—LUTHER M. HALSEY, Williamstown, Sept. 17, 1858—Mar. 20, 1921. Legislative Committee. J, 1921, p. 127; GR, No. 68. Portrait in Editorial Office.
115. 1900—WILLIAM PIERSON, JR., Orange, Nov. 20, 1830—June 12, 1900. Secretary 31 years, as was his father, William, No. 83, Secretary 1866-1897. T, 1901, p. 296; GR, No. 57; Portrait, J, 1916, p. 291.
116. 1901—JOHN D. MCGILL, Jersey City, Dec. 23, 1846—Nov. 28, 1912. Surgeon General of N. J. Banker. J, 1913, p. 429; J, 1916, p. 280; GR, No. 58.
117. 1902—EDWARD L. B. GODFREY, Camden, Feb. 21, 1850—Dec. 17, 1913. Wrote "Medical History of Camden County"—an ideal book. A born leader. J, 1914, pp. 25, 34, 47; GR, No. 59.
118. 1903—HENRY MITCHELL, Asbury Park, Aug. 6, 1845—Jan. 31, 1919. Public health and State Department of Health. J, 1919, p. 100, also portrait, p. 106; J. Feb., 1920, p. 52, also portrait; GR, No. 69.
119. 1904—WALTER B. JOHNSON, Paterson, Jan. 3, 1852—1922. Eye and ear specialist. Portrait J, 1904, p. 31; J, 1925, p. 350 with portrait; portrait J, 1916, p. 278; GR, No. 70. Photograph hangs in Editorial Office.
120. 1905—HENRY W. ELMER, Bridgeton, Apr. 26, 1847—Feb. 13, 1907. Active in civic duties. J, 1907, Mar., p. 240; GR, No. 60.
121. 1906—ALEXANDER MARCY, JR., Riverton, 1860—May 1, 1934. J, 1934, p. 376; GR, No. 71.
122. 1907—EDWARD J. ILL, Newark. Born 1854. Senior Fellow. GR, No. 72.
123. 1908—DAVID ST. JOHN, Hackensack, Mar., 1850—Sept. 14, 1917. "A doctor of the old school." J, 1917, p. 411 with portrait; GR, No. 73.
124. 1909—BENJAMIN A. WADDINGTON, Salem. 1842—Aug. 23, 1917. J, 1917, pp. 412 and 451; GR, No. 74.
125. 1910—THOMAS H. MACKENZIE, Trenton, Mar. 14, 1847—Oct. 19, 1920. Surgeon. A gentleman of the old school. J. Nov., 1920, p. 400; GR, No. 75. Large portrait July, 1911, frontispiece.
126. 1911—DAVID STROCK, Camden, 1850—July 10, 1927. Sanitarian, church organist. Portrait frontispiece J, 1912, July; J, 1927, p. 490; GR, No. 76.
127. 1912—NORTON L. WILSON, Elizabeth, 1861—Nov. 13, 1931. "Quiet wisdom." J. 1931, p. 950, portrait; GR, No. 77.
128. 1913—ENOCH HOLLINGSHEAD, Pemberton, 1843—Feb. 23, 1924. Treasurer, Burlington County Medical Society 34 years. J, 1924, pp. 112 and 142, portrait; GR, No. 78.
129. 1914—FRANK D. GRAY, Jersey City, 1857—June 11, 1916. Active and original. J, 1916, pp. 389, 391; GR, No. 79.
130. 1915—WILLIAM J. CHANDLER, South Orange, July 11, 1842—Oct. 30, 1927. Secretary 15 years. Chairman, Publication Committee. Organist. J, 1927, p. 711, portrait; GR, No. 80.
131. 1916—PHILIP MARVEL, Sept. 15, 1856—Sept. 6, 1938. Active and prominent. J, 1938, p. 642. Photograph hangs in Editorial Office.
132. 1917—WILLIAM G. SCHAUFFLER, Lakewood, Oct. 28, 1862—Apr. 30, 1933. President, New Jersey Health and Sanitary Association. J, 1933, p. 515.
133. 1918—THOMAS W. HARVEY, Orange, Sept. 10, 1853—Apr. 8, 1938. Active on Welfare Committee. J, 1938, p. 326; portrait frontispiece Jan., 1919. Photograph hangs in Editorial Office.
134. 1919—GORDON K. DICKINSON, Jersey City, Dec. 14, 1855—June 25, 1930. Leader in tuberculosis work. J, 1930, p. 683, portrait.
135. 1920—PHILANDER A. HARRIS, Paterson, Jan. 29, 1852—Dec. 13, 1924. Gynecologist and author. Health Commissioner. J, 1925, pp. 32 and 60. Photograph hangs in Editorial Office.
136. 1921—HENRY B. COSTILL, Trenton, 1860—Apr. 27, 1935. Medical legislation and public health. Portrait J, 1922, Oct., p. 270; J, 1935, p. 327.
137. 1922—JAMES HUNTER, JR., Westville, Jan. 14, 1866—June 1, 1931. Active in State Society. J, 1931, p. 601 and portrait; J, 1923, p. 217.
138. 1923—WELLS P. EAGLETON, Newark. Born 1865.

139. 1924.—ARCHIBALD MERCER, Newark, 1849—Nov. 3, 1931. Assistant Director, Mutual Life Ins. Co. of N. J. J, 1931, p. 990. Photograph hangs in Editorial Office.
140. 1925—**LUCIUS DONOHOE**, Bayonne. Born 1868.
141. 1926—JAMES S. GREEN, JR., Elizabeth, 1864—Jan. 30, 1936. "A practical idealist." Son of No. 105. J, 1936, p. 113. Photograph hangs in Editorial Office.
142. 1927—**WALT P. CONAWAY**, Atlantic City. Born 1873.
143. 1928—EPHRAIM R. MULFORD, Burlington, Oct. 17, 1880—Mar. 10, 1939. Active in civic medicine. J, 1939, p. 241, with portrait, and Memorial, p. 387. Photograph hangs in Editorial Office.
144. 1929—**ANDREW F. McBRIDE**, Paterson. Born 1869.
145. 1930—**GEORGE N. J. SOMMER**, Trenton. Born 1874.
146. 1931—JOHN F. HAGERTY, Newark, May 9, 1869—Feb. 1, 1937. Surgeon, scholar, church worker, musician. J, 1937, pp. 127, 186, and 347, with portraits. Photograph hangs in Editorial Office.
147. 1932—A. HAINES LIPPINCOTT, Camden, July 12, 1867—Mar. 10, 1937. Urologist, Cooper Hospital, J, 1937, p. 290, with portrait. Photograph hangs in Editorial Office.
148. 1933—**FREDERIC J. QUIGLEY**, Union City. Born 1883.
149. 1934—**LANCELOT ELY**, Somerville. Born 1875.
150. 1935—**MARCUS W. NEWCOMB**, Brown's Mills. Born 1880.
151. 1936—**FRANCIS R. HAUSSLING**, Newark. Born 1875. Resigned because of ill health.
152. 1936—**SPENCER T. SNEDECOR**, Hackensack. Born 1900.
153. 1937—**WILLIAM G. HERRMAN**, Asbury Park. Born 1890.
154. 1938—**WILLIAM J. CARRINGTON**, Atlantic City. Born 1884.
155. 1939—**E. ZEH HAWKES**, Newark. Born 1865.
156. 1940—**WATSON B. MORRIS**, Springfield. Born 1878.

The names of living Fellows are in bold face type.

2. THE HONORARY MEMBERS

The principal source of information on the lives of the Honorary Members is "American Medical Biographies", by H. A. Kelly and W. L. Burrage.

The records of their election to honorary membership are taken from the official minutes of the Annual Meetings.

Year of
Election

1. 1827—**DAVID HOSACK**, New York, 1769-1835. Professor of Botany and Obstetrics in the Medical School of Columbia University, and later, in the Medical Department of Queens (Rutgers) College, New Brunswick. (Wickes' History, p. 39.)
2. 1827—**JOHN W. FRANCIS**, New York, 1789-1869. Associated with Dr. Hosack in Columbia and in Rutgers. Writer on medical, and also popular subjects, such as "Old New York".
3. 1830—**JOHN CONDUCT**, Orange, 1755-1834. Physician, soldier, U. S. Senator. (Biog. Wickes, p. 210.)
4. 1839—**USHER PARSON**, Providence, Rhode Island, 1788-1868. President Rhode Island Medical Society. Naval surgeon in War of 1812, and the only surgeon on duty at the Battle of Lake Erie.
5. 1839—**REUBEN D. MUSSEY**, Cincinnati, Ohio, 1780-1866. An original genius, investigator, and writer. (Trans., Vol. 1, p. 347.)
6. 1839—**ALBAN G. SMITH**, New York.
7. 1843—**WILLARD PARKER**, New York, 1800-1884. Professor of Surgery, College of Physicians and Surgeons.
8. 1845—**VALENTINE MOTT**, New York, 1785-1865. Surgeon both bold and famous.
9. 1848—**JONATHAN KNIGHT**, New Haven, 1789-1864. Leading surgeon. Twice President A.M.A.
10. 1848—**NATHANIEL CHAPMAN**, Philadelphia, 1780-1853. Author of a leading book on therapeutics. Skilled in lecturing and story-telling.
11. 1848—**ALEXANDER H. STEVENS**, New York, 1789-1869. Surgeon and editor.
12. 1849—**JOHN C. WARREN**, Boston, 1778-1856. Leader in Boston surgery; founded Massachusetts General Hospital; and established the New England Medical and Surgical Journal.
13. 1850—**LEWIS C. BECK**, New York, 1798-1853. Professor of Chemistry, Rutgers College.
14. 1850—**JOHN C. TORREY**, New York, 1796-1873. Professor of Chemistry, Princeton University. Famous Botanist.
15. 1853—**GEORGE B. WOOD**, Philadelphia, 1797-1879. University of Pennsylvania. Voluminous writer. Wrote a standard dispensatory.
16. 1854—**HORACE A. BUTTOLPH**, Short Hills, N. J., 1815-1898. First superintendent N. J. State Hospital for the Insane in Trenton, and builder and superintendent of the State Hospital at Greystone Park.
17. 1861—**ASHBEL**, WOODWARD, Franklin, Conn. 1804-1885. Antiquarian and Historian. President Connecticut Medical Society.
18. 1861—**THOMAS W. BLATCHFORD**, Troy, N. Y., 1794-1866. All-round writer on health topics.
19. 1867—**JEREMIAH S. ENGLISH**, Manalapan, N. J., 1793-1879. Treasurer of State Society thirty-three years. 1833-1866. Literary and religious. (Trans., 1880, p. 117.)
20. 1868—**STEPHEN WICKES**, Orange, N. J., 1813-1889. President of State Society 1883. The great historian of The Medical Society of New Jersey; the biographer of its members; and the preserver of the records of the State Society.
21. 1872—**SAMUEL OAKLEY VANDERPOEL**, Albany, N. Y., 1824-1886. Pathologist. Professor of Public Hygiene in New York University.

22. 1872—JOSEPH PARRISH, Burlington, N. J., 1818-1891. President 1885. Editor. Established a training school for idiots. A leader in the Sanitary Commission during the Civil War.
23. 1872—FERRIS JACOBS, Delhi, N. Y., 1802-1880. Born and practiced in a small country village. A surgeon in the Civil War. Did a large surgical practice, and was among the earliest to operate for appendicitis.
24. 1872—CHARLES A. LINDSLEY, New Haven, Conn., 1826. Professor of Therapeutics, Yale Medical School; Health Officer of New Haven.
25. 1876—WILLIAM PEPPER, Philadelphia, 1843-1898. Professor of Medicine, University of Pennsylvania.
26. 1876—S. WEIR MITCHELL, Philadelphia, 1829-1914. An authority on neurology and surgery of the nervous system. (Citation, Trans., 1876, p. 37.)
27. 1880—CYRUS F. BRACKETT, Princeton, N. J., 1834-1915. Professor Physics, Princeton University, for 35 years. (A. M. A. Jour.)
28. 1880—JOSEPH C. HUTCHINSON, Brooklyn, 1827-1887. Wrote school text books in Physiology and Hygiene.
29. 1884—THOMAS ADDIS EMMETT, New York, 1828-1919. Gynecologist. Writer.
30. 1884—ISAAC E. TAYLOR, New York, 1812-1889. Gynecologist.
31. 1886—D. HAYES AGNEW, Philadelphia, 1818-1892. Surgeon. Attended President Garfield.
32. 1886—JOSEPH LEIDY, Philadelphia, 1823-1891. Anatomy and Paleontology. Voluminous publication.
33. 1893—FREDERICK S. DENNIS, New York, 1850-1934. Professor of Surgery, Bellevue Medical School. Wrote History of Surgery.
34. 1893—JOHN HOWARD RIPLEY, New York, 1813-1896. Surgeon.
35. 1893—VIRGIL P. GIBNEY, New York, 1847-1927. As skilled orthopedist.
36. 1894—WILLIAM PIERSON, Orange, 1830-1900. Belonged to the fourth generation of physicians. President of the State Society, as were his father and grandfather. Secretary of State Society for thirty-one years.
37. 1896—ABRAHAM JACOBI, New York, 1830-1919. A pioneer in Pediatrics.
38. 1896—VIRGIL M. D. MARCY, Cape May City, 1823-1904. Prominent and active in practice for half a century.
39. 1897—SAMUEL H. PENNINGTON, Newark, 1806-1900. President 1848. Learned and practical in medical, civic, and financial affairs. (Obituary, Trans., 1900, p. 186.)
40. 1901—ALFRED A. WOODHULL, Princeton, 1837-1921. Had a distinguished career as an army officer. (Trans., 1901, p. 66.)
41. 1902—J. LEONARD CORNING, New York, 1855-1923. Developed spinal anesthesia.
42. 1903—JOHN ALLEN WYETH, New York, 1845-1922. Surgeon. Founder of the New York Polyclinic.
43. 1903—WILLIAM K. VAN REYPEN, Surgeon General. U. S. N., 1840-1924. Designed the first ambulance ship.
44. 1903—LAWRENCE F. FLICK, Philadelphia, 1856-1938. Writer on Tuberculosis.
45. 1906—S. ADOLPHUS KNOPF, New York, 1857-1940. A pioneer in Tuberculosis.
46. 1907—ALBERT VANDER VEER, Albany, 1841-1929. One of a family of medical leaders and educators. Kin to the New Jersey Vander Veers. Dean of the Albany Medical School.
47. 1916—CHARLES K. MILLS, Philadelphia, 1845-1931. Professor of Neurology, University of Pennsylvania.
48. 1916—RICHARD C. CABOT, Boston, 1868-1939. Professor of Clinical Medicine and Social Ethics, Harvard Medical School. Author of medical books.
49. 1916—GEORGE W. CRILE, Cleveland, 1864. A leader in endocrinology.
50. 1916—JOHN B. DEAVER, Philadelphia, 1855-1931. A leading surgeon, and genial companion.
51. 1923—WILLIAM J. CHANDLER, South Orange, 1842-1927. President of State Society 1915. A hard worker and born leader.
52. 1925—EDWARD J. ILL, Newark, 1854. President of State Society 1907. Gynecologist. Leader in medical education.
53. 1930—JOSEPH E. RAYCROFT, Princeton, 1867. Professor of Health and Physical Education, Princeton University.
54. 1933—JACKSON B. PELLETT, Hamburg, N. J., 1847-1939. Ophthalmologist. Active in medical society work.
55. 1935—WELLS P. EAGLETON, Newark, 1865. President of State Society, 1923. Brain surgery, and medical administration. Promoted the Welfare Committee.
56. 1935—VANDERHOEF M. DISBROW, Lakewood, 1857-1930. One of the second of three generations of physicians in one family, all leaders in medicine.
57. 1935—PHILIP MARVEL, Atlantic City, 1856-1938. President of State Society, 1916. Active in organized medicine and civil life.
58. 1936—JOSEPH B. HARRISON, Westfield, 1852-1940. Attended every annual meeting of the State Society for sixty-four years.
59. 1936—THOMAS W. HARVEY, Orange, 1853-1938. President of State Society, 1918. Active on the Welfare Committee.
60. 1936—ANDREW F. McBRIDE, Paterson, 1869. President of State Society, 1929. A wise and willing worker. Mayor of Paterson. Commissioner of Labor of New Jersey.
61. 1939—ROCK SLEYSTER, Wauwatosa, Wisc., 1879. Psychiatrist. President A. M. A., 1939.
62. 1939—NATHAN B. VAN ETTE, New York, 1866. Internal Medicine. President A. M. A., 1940.
63. 1939—HAVEN EMERSON, New York, 1874. Professor of Public Health Practice, College of Physicians and Surgeons, New York.
64. 1940—JAMES EWING, New York, 1866. Pathologist and cancer specialist in the Memorial Hospital. New York. Teacher and writer.

The names of living Honorary Members are in bold face type.

An Alphabetical List of the Members of the Medical Society of New Jersey

COMPILED MARCH 15, 1941

The figures in parenthesis refer to County Societies as follows: (1) Atlantic, (2) Bergen, (3) Burlington, (4) Camden, (5) Cape May, (6) Cumberland, (7) Essex, (8) Gloucester, (9) Hudson, (10) Hunterdon, (11) Mercer, (12) Middlesex, (13) Monmouth, (14) Morris, (15) Ocean, (16) Passaic, (17) Salem, (18) Somerset, (19) Sussex, (20) Union, (21) Warren.

*Deceased.

A

ACTIVE MEMBERS

- Abbate, Charles C., 32 Main st., Lodi (2)
 Abel, Arthur R., 144 Harrison st., East Orange (7)
 Abel, Henri E., 339 Union av., Elizabeth (20)
 Abey, Wm. J. H., 21 E. Delaware av., Pen'gton (11)
 Abrams, Abram B., 299 Clinton av., Newark (7)
 Abrams, Henry, 195 Nassau st., Princeton (11)
 Abramson, Solomon, 1587 Irving st., Rahway (20)
 Ackerhalt, Martin J., 408 Clifton av., Clifton (16)
 Ackerman, Arthur F., 129 Summit av., Summit (20)
 Ackermann, Edward, 5 Richards av., Dover (14)
 Ackley, David B., 21 N. Clinton av., Trenton (11)
 Adams, Geo. B. M., 304 Monmouth st., Gloucester (4)
 Adams, Rayford K., Lakeside Lodge, Skillman (18)
 Adelman, Benjamin B., 190 Clinton av., Newark (7)
 Adler, Joseph, 933 Ave. C, Bayonne (9)
 Africano, Julius V., 2700 Hudson Blvd., Union C'y (9)
 Agayoff, John D., 127 S. Wash'g't'n av., B'rgenfd (2)
 Agnew, Hobart M., 17 Plymouth st., Montclair (7)
 Agolia, Michael W., 441 Palisade av., Union City (9)
 Ainsley, H. Bryson, 246 Union st., Jersey City (9)
 Aitken, Frank J., 119 N. Pearl st., Bridgeton (6)
 Aitken, Herbert M., Ogdensburg (19)
 Albano, Edwin H., 242 Clifton av., Newark (7)
 Albano, Frank J., 535 N. 7th st., Newark (7)
 Albano, Joseph, 535 N. 7th st., Newark (7)
 Albert, Perry, 2780 S. Broad st., Trenton (11)
 Albrecht, Wm. J., 25 N. Bridge st., Somerville (18)
 Albright, Louis F., 118 Madison av., Spring Lake (13)
 Alcamo, John H., 215 Littleton av., Newark (7)
 Alexander, Samuel, 12 Main st., Park Ridge (2)
 Alexander, Walter G., 48 Webster pl., Orange (7)
 Alford, Ralph I., 83 Park st., Montclair (7)
 Allaben, Anna L., 165 South st., Morristown (14)
 Allan, James S., 144 Harrison st., East Orange (7)
 Allegrante, A. J., Washington Val. rd., Martinsville
 Allen, Arthur A., 365 Park av., Paterson (16)
 Allen, Chester B., Jr., 254 Midland av., Montclair (7)
 Allen, G. Herbert, 181 Roseville av., Newark (7)
 Allen, Isaac L., 521 Palisade av., Union City (9)
 Allen, James M., 657 Main av., Passaic (16)
 Allen, Raymond N., 144 Harrison st., E. Orange (7)
 Alling, Frederic A., 15 Washington st., Newark (7)
 Allman, David B., 104 St. Charles pl., Atlantic C'y (1)
 Alpert, Edward, 661 Jersey av., Jersey City (9)
 Alpren, Bernard F., 34 Auburn st., Paterson (16)
 Alter, Nicholas M., 410 Fairmount av., Jersey C'y (9)
 Altman, Charles D., 301 Highland av., Newark (7)
 Altschul, Frank J., 177 Gar'd av., Long Branch (13)
 Ambrose, Anthony, 71 Congress st., Newark (7)
 Ambrose, Robert R., 124 Hamilton st., Bound Br'k (18)
 Amdur, Louis A., 2540 Boulevard, Jersey City (9)
 Anderson, John F., 195 College av., New Bruns. (12)
 Anderson, Reuben M., 408 Main st., Hackens'k (2)
 Anderson, Richard D., 465 High st., Burlington (3)
 Anderson, Robt. C., 686 Mt. Prospect av., Newark (7)
 Anderson, William A., 1255 Broad st., Bloomfield (7)
 Anderson, Wm. M., 20 Kings Hwy. W., Haddonfd (4)
 Andrews, Clarence L., 1616 Pacific av., Atl. City (1)
 Andrus, David L., 805 Cooper st., Camden (4)
 Angelillis, Paul, 76 State st., Hackensack (2)
 Anrig, Grace E., 133 Summit av., Union City (9)
 Anson, Leon J., 314 Center st., Garwood (20)
 Antonius, Nicholas A., 27 W. Market st., Newark (7)
 Antopol, Wm. A., 201 Lyons av., Newark (7)
 Anuario, Chas. B., 365 S. Centre st., Orange (7)
 Applebaum, Irving L., 31 Lincoln Park, Newark (7)
 Applegate, Edw. T. R., 1125 Greenw'd av., Tr'nt'n (11)
 Applestein, Robert, 568 E. State st., Trenton (11)
 Appleton, Ralph, Lincoln av., Pt. Pleasant (15)
 Appold, Geo. D., 60 E. Church st., Bergenfield (2)
 Apter, Abraham H., 528 E. 29th st., Paterson (16)
 Arbeit, Sidney R., 2521 Boulevard, Jersey City (9)
 Areson, Wm. H., 153 Bellevue av., Up. Montclair (7)
 Aria, Michael H., 31 Glenwood av., Jersey City (9)
 Arlitz, William J., 107 Newark st., Hoboken (9)
 Armstrong, Lorrimer B., 121 S. Euclid av., W'stfd (20)
 Arndt, Frank R., 7500 Bergenline av., N. Bergen (9)
 Aronis, Harry R., 239 E. Hanover st., Trenton (11)
 Aronowitz, Harry T., 932 Ave. C, Bayonne (9)
 Arons, Harry, 717 High st., Newark (7)
 Artaserse, Geo. V., 185 Bergen av., Jersey City (9)
 Arthur, Frances H., 138 Westfield av., Elizabeth (20)
 Ash, Arthur F., 710 Boulevard, E., Weehawken (9)
 Ash, Frank W., 180 Carroll st., Paterson (16)
 Ash, Samuel, 25 Johnson av., Newark (7)
 Asher, Maurice, 186 Clinton av., Newark (7)
 Ashley, Harmon H., 192 W. State st., Trenton (11)
 Assante, M. Hugo, Evesham av., Magnolia (4)
 Aszody, Paul, 340 Waverly av., Newark (7)
 Athey, Kenneth L., 3616 Westfield av., Camden (4)
 Atkinson, James Q., State Colony, New Lisbon (3)
 Atkinson, James W., 603 S. Maple av., Glen Rock (16)
 Atkinson, John M., 93 Greenwood av., Madison (14)
 Atwell, David R., 920 Hudson st., Hoboken (9)
 Atwood, Edward A., 360 Park av., Paterson (16)
 Auriemma, Michele, 419 Adams st., Hoboken (9)
 Austin, Thomas R., 19 Holly st., Cranford (20)
 Averbach, Jacob, 435 Clifton av., Clifton (16)
 Avery, Philip S., 546 Central av., Bound Brook (12)
 Axford, W. Homer, Chester (9)

ASSOCIATE MEMBERS

- Adelman, Nathan, 208 Renner av., Newark (7) Andermann, Eugenie, 68 E. 86th st., New York C'y (7)
 Austin, Henry J., 96 Bellevue av., Trenton (11)

B

ACTIVE MEMBERS

- Babbitt, Hugh M., Jr., 950 Park av., Plainfield (20)
 Bachmann, Wm., 87 Hillcrest ter., East Orange (7)
 Bacon, Mary, 278 E. Commerce st., Bridgeton (6)
 Bacote, Ernest F., 78 Barclay st., Newark (7)
 Baeseman, R. Winfield, 501 Grand av., Asb. P'k (13)
 Bagg, Linus W., 31 Lincoln Park, Newark (7)
 Bahnson, Conrad M., 170 Bowers st., Jersey City (9)
 Bailyn, Emanuel, 331 16th st., West New York (9)
 Baiocchi, Pascal J., 203 Hunterdon st., Newark (7)
 Baird, Thompson M., 1625 32d st., S., St. P't's b'g, Fla. (7)
 Baker, Augustus L., 389 W. Blackwell st., Dover (14)
 Baker, Banks S., 601 Walnut st., Camden (4)
 Baker, Charles F., 193 Clinton av., Newark (7)
 Baker, Clifford, 8th and Elmer sts., Vineland (6)
 Baker, Elsworth F., State Hospital, Marlboro (13)
 Baker, Hugh W., 8th & Elmer sts., Vineland (6)
 Baker, Maclyn F., 638 Stuyvesant av., Irvington (7)
 Baker, Maurice E., 1149 Kaighn av., Camden (4)
 Baker, Philip W., High Bridge (10)
 Baker, Raymond D., 52 DeForest av., Summit (20)
 Baketel, H. Sheridan, 155 Van Wagenen av., Jer. C'y (2)
 Baldauf, Herman, Jr., Front st., Belvidere (21)
 Baldwin, John F., 1474 Windsor rd., W. Englew'd (2)
 Baldwin, Samuel H., 626 Clinton av., Newark (7)
 Ballinger, Reeve L., 659 Kearny av., Arlington (9)
 Balogh, William A., 315 Front st., Dunellen (12)
 Balsamo, Anthony J., 212 52nd st., W. New York (9)
 Balson, Zachary D. B., 49 Osborne ter., Newark (7)
 Balze, Henry R., 147 Christie st., Leonia (2)
 Bambara, Aurelius J., Flemington (10)
 Banker, George T., 1145 E. Jersey st., Elizabeth (20)
 Banta, Raymond E., 118 E. Clinton av., Tenafly (2)
 Bar, Samuel, 54 Main st., Englishtown (13)
 Barb, Kirk B., 1303 Princess av., Camden (4)
 Barbarito, Wm. N., 135 Bentley av., Jersey City (9)
 Barbash, Roslyn H. W., 835 Red rd., Teaneck (2)
 Barbash, Samuel, 1902 Pacific av., Atlantic City (1)
 Barberio, A. Arthur, 1337 Orange av., Union (20)
 Barbour, George E., 118 W. High st., Somerville (18)
 Barishav, Samuel B., 5 Bentley av., Jersey City (9)
 Barkhorn, Charles W., 223 Roseville av., Newark (7)
 Barkhorn, Henry C., 45 Johnson av., Newark (7)
 Barlow, Frank A., 965 Madison av., Paterson (16)
 Barlow, G. Barton, 157 Engle st., Englewood (2)
 Barnard, Frank G., 22 Plymouth st., Montclair (7)
 Barnes, William J., 155 Engle st., Englewood (2)
 Barnshaw, Harold D., 2626 Federal st., Camden (4)
 Barolsky, Benjamin, 306 Broadway, Paterson (16)
 Baron, Herbert A., 150 Terrace av., Hasb'r'k Hgts. (2)
 Baron, Leo E., 727 N. Wood av., Linden (20)
 Barr, Joseph, 975 Madison av., Paterson (16)
 Barrett, John E., 635 Summer av., Newark (7)
 Barrett, Joseph F., 230 Parker av., Maplewood (7)
 Barroway, James N., 3064 Federal st., Camden (4)
 Barrows, Arthur M., 440 Hamilton av., Trenton (11)
 Barrows, Victor I., 316 N. Broadway, Pitman (8)
 Barry, R. Grant, 908 W. State st., Trenton (11)
 Bartlett, Clara K., 4301 Atlantic av., Atlantic C'y (1)
 Baruch, Rudolf J., 202 Stiles st., Elizabeth (20)
 Basralian, Jos. B., 238 Blvd., Hasbrouck Heights (2)
 Bassett, Lavern C., 320 New Market rd., Dunell'n (12)
 Bassett, Norman H., 1616 Pacific av., Atl. City (1)
 Baum, Felix, 10 Elm court, South Orange (7)
 Baum, Samuel, 10 Osborne ter., Newark (7)
 Bauman, Everett O., 17 Hillside av., Newark (7)
 Bauman, Kenneth R., 213 N. 3rd av., Millville (6)
 Bauman, Rush C., 92 High st., Nutley (7)
 Bayne, Jos. K., Med. Dpt., 112th F.A., Ft. Bragg, N.C. (11)
 Beairsto, Everett B., 224 W. State st., Trenton (11)
 Beatty, Hannah J., Clinton Farms, Clinton (10)
 Beaver, Jennie D., 44 Elm st., Morristown (14)
 Becker, C. Frederick, 620 Benson st., Camden (4)
 Becker, Frank F., 298 Diamond Br. av., Hawthorne (16)
 Becker, Frederick W., 14 Clinton pl., Newark (7)
 Becker, George L., 646 E. 28th st., Paterson (16)
 Becker, Leo V., 69 Ward st., Paterson (16)
 Becker, Martin, 94 S. Munn av., East Orange (7)
 Becker, Sidney D., 140 Maple pl., Keyport (13)
 Becket, George C., 350 Springdale av., E. Orange (7)
 Behrens, Herman H. E., 312 Webster av., Jer. C'y (9)
 Beideman, Casper M., 5 W. Maple av., Merch'tv'le (4)
 Beir, Ily R., 3900 Atlantic av., Atlantic City (1)
 Beisler, Lawrence G., 1528 N. Broad st., Hillside (20)
 Belafsky, Henry A., 150 Greene st., W'dbridge (12)
 Belfer, Jacob J., 1235 Chambers st., Trenton (11)
 Belford, Ralph J., 90 Nassau st., Princeton (11)
 Beling, C. Abbott, 111 Clinton av., Newark (7)
 Beling, Christopher C., 111 Clinton av., Newark (7)
 Bell, Horace O., Essex Co. Isolation Hosp., B'lev'le (7)
 Bellak, Ellis R., Leesburg (6)
 Bellis, Horace D., 437 E. State st., Trenton (11)
 *Belting, Arthur W., 836 W. State st., Trenton (11)
 Ben-Asher, Solomon, 260 Bergen av., Jersey City (9)
 Bender, Theodore, 666 Broadway, Paterson (16)
 Bendix, Gerhard M., 56 E. Somerset st., Raritan (18)
 Benjamin, Harold C., 59 Crescent av., Jersey City (9)
 Benjamin, Jos. F., 203 Godwin av., Ridgewood (16)
 Bennett, Samuel D., 118 Pine st., Millville (6)
 Bennett, Wm. F., Essex Mt. Sanatorium, Verona (7)
 Bensley, Maynard G., 129 Summit av., Summit (20)
 Bentley, David F., Jr., 406 Cooper st., Camden (4)
 Berardinelli, Carmine G., 92 8th av., Newark (7)
 Berenson, Sam'l J., 1012 E. Jersey st., Elizabeth (20)
 Beres, Albert J., 492 Wood-Ridge av., Wood-Ridge (2)
 Berg, Samuel, 156 Roseville av., Newark (7)
 Berger, Wm. A., 346 Roseville av., Newark (7)
 Bergin, Joseph V., 315 Broadway, Paterson (16)
 Bergman, Meyer W., 31 Lincoln Park, Newark (7)
 Bergmann, Ewald H., 44 Bank st., Sussex (19)
 Bergmeyer, Josef T., 422 64th st., W. New York (9)
 Berk, M. David, 33 Bartholf av., Pompton Lks. (16)
 Berke, Raynold N., 430 Union st., Hackensack (2)
 Berkhout, Peter G., 106 Haledon av., Prosp't P'k (16)
 Berkow, Samuel G., 138 Market st., P'h Amboy (12)
 Berkowitz, Benj., 188 E. Commerce st., Bridgeton (6)
 Berlin, Joseph I., 2600 Hudson Blvd., Jersey City (9)
 Berman, H. Robert, 286 Roseville av., Newark (7)
 Berman, Jacob J., 409 Market st., Trenton (11)
 Berman, Leonard M., 155 Summit av., Summit (20)
 Berman, Sol, 351 Rahway av., Elizabeth (20)
 Bernhard, Wm. G., 142 Clinton av., Newark (7)
 Bernheisel, Louis E., Reading av., Tuckahoe (5)
 Bernson, Samuel T., 653 S. 18th st., Newark (7)
 Bernstein, Arthur, 668 Clinton av., Newark (7)
 Bernstein, Benedict J., 434 E. Front st., Plainf'd (20)
 Berry, C. Hartley, 129 Summit av., Summit (20)
 Bertha, Nicholas A., 301 S. Main st., Wharton (14)
 Beshlian, Hagop K., 7 Lee pl., Paterson (16)
 Besson, Franklin J., 999 Clinton av., Irvington (7)
 Betancourt, Raul R., 406 Cooper st., Camden (4)
 Betts, R. Winfield, 22 N. Main st., Medford (3)
 Beveridge, Wm. W., 1000 Grand av., Asbury P'k (13)
 Bianchi, Angelo R., 184 Hunterdon st., Newark (7)
 Bickner, Alvah W., 84 Park av., Rutherford (2)
 Biczak, Arkad K., 311 Lexington av., Clifton (16)
 Bien, Frank A., 999 Clinton av., Irvington (7)
 Bigelow, Elizabeth F., 120 Prospect st., S. Orange (7)
 Bigelow, Nelson S., 120 Prospect st., S. Orange (7)
 Bigliani, Urban R., 606 80th st., North Bergen (9)
 Binder, Joseph, 101 3rd av., Long Branch (13)
 Bingham, Arthur W., 144 Harrison st., E. Orange (7)
 Bird, Frank L., Main st., Netcong (14)

- Birdsall, Clarence A., 9 Smull av., Caldwell (7)
 Birrell, Russell G., 554 Westminster av., Elizabeth (20)
 Bishop, Carl, 831 Madison av., Plainfield (20)
 Bissett, John V., 29 Hawthorne av., East Orange (7)
 Bitten, Robt. M., 33 Romaine av., Jersey City (9)
 Black, LeRoy W., 33 W. Passaic av., Rutherford (2)
 Black, Maskell B., 139 E. High st., Glassboro (8)
 Black, Max S., 1320 St. George av., Linden (20)
 Blackburne, George, 490 Central av., Newark (7)
 Blackwell, Enoch, 28 W. State st., Trenton (11)
 Blair, Thomas D., 414 Park av., Plainfield (20)
 Blaisdell, C. Byron, 489 Broadway, Long Branch (13)
 Blakey, Abram P., 155 Wegman Pkwy., Jer. City (9)
 Blanchard, Charles L., 28 E. Blackwell st., Dover (14)
 Blanchard, Kenneth, 25 S. Munn av., E. Orange (7)
 Blank, Samuel, N. J. State Village, Skillman (18)
 Blatt, David, 960 Madison av., Elizabeth (20)
 Blaugrund, Samuel, 190 W. State st., Trenton (11)
 Blaustein, Maurice L., 37 Hillside av., Newark (7)
 Blauvelt-Wells, Grace B., 76 Heights rd., Ridgewood (2)
 Bleasby, Charles B., 136 Passaic st., Garfield (2)
 Bleiberg, Jacob, 31 Lincoln Park, Newark (7)
 Bleick, Theodore E., 61 Van Ness pl., Newark (7)
 Blenke, Victor A., 140 Chadwick rd., Teaneck (2)
 Bloch, Harry, 613 N. Broad st., Elizabeth (20)
 Block, Marcus T., 177 Bloomfield av., Newark (7)
 Block, Max, 48 N. Fullerton av., Montclair (7)
 Block, Milton, 711 Chancellor av., Irvington (7)
 Blum, Joseph M., 128 Mill st., Trenton (11)
 Blumberg, A. William, New Egypt (15)
 Blumberg, Jack, 504 Westminster av., Elizabeth (20)
 Blythe, Rowland P., 30 Springfield av., Cranford (20)
 Bobadilla, Juan E. B., 2 Mercer st., Dover (14)
 Bocchini, Joseph A., 366 S. 12th st., Newark (7)
 Bohl, Louis J., 320 Broadway, Paterson (16)
 Boland, Lucy E., 27 Washington av., Arlington (9)
 Bolanowski, Kasimier J., 145 Marshall st., Elizabeth (20)
 Bonanno, Peter J., 500 79th st., North Bergen (9)
 Bongiorno, Henry D., 516 River st., Paterson (16)
 Bonnet, W. Laurence, 2791 Notgh'm w'y, M'r'c'rv'le (11)
 Bonyng, Henry A., 123 Prospect st., Ridgewood (16)
 Bookrajan, Edward N., 8027 Boulevard, N. Bergen (9)
 Bookstaver, Barnett S., 193 Norma rd., Teaneck (2)
 Booth, George R., 219 Highland av., Westville (8)
 Booth, Walter S., 318 Grier av., Elizabeth (20)
 Booth, William K., 304 William st., Boonton (14)
 Boothby, I. Roland, Clinton (10)
 Boozan, Wm. E., 1139 E. Jersey st., Elizabeth (20)
 Boquist, Walter A., 380 Hudson st., Phillipsburg (21)
 Bornstein, David, 80 Carroll st., Paterson (16)
 Bornstein, Paul K., 415 S. Lake dr., Belmar (15)
 Borow, Benjamin, 507 Church st., Bound Brook (18)
 Borow, Henry, 507 Church st., Bound Brook (18)
 Borow, Louis S., 507 Church st., Bound Brook (18)
 Borow, Maurice, 507 Church st., Bound Brook (18)
 Borrella, Dominic D., 476 Hamilton av., Trenton (11)
 Borrone, Milton G., 2695 Boulevard, Jersey City (9)
 Borshaw, Hyman, 108 Bentley av., Jersey City (9)
 Borsher, Irving P., 249 Broad st., Bloomfield (7)
 Bortone, Frank, 2765 Boulevard, Jersey City (9)
 Bosch, Taeke, Goffle Hill rd., Wyckoff (2)
 Boselli, Emile H., 614 15th st., Union City (9)
 Bossard, Harry B., R. D. No. 2, Phillipsburg (21)
 Bossert, Chas. L., 4021 Atlantic av., Atlantic City (11)
 Bostwick, Delazon S., Cumberl'd Hotel, Bridgeton (6)
 Bostwick, Wallace R., Main st., Blairstown (21)
 Botbyl, Burt W., 927 Madison av., Paterson (16)
 Botti, John A., 236 Summit av., Jersey City (9)
 Bourns, Edward G., 203 S. Euclid av., Westfield (20)
 Bove, Joseph, 306 Lincoln av., Orange (7)
 Bowen, Robt. N., Ev'rgr'n & W'dlyne avs., W'dlyne (4)
 Bowers, F. Clyde, Mountain av., Mendham (14)
 Bowersox, Clarence A., 509 N. Broad st., Woodbury (8)
 Bowles, Harry H., 36 Woodland av., Summit (20)
 Bowman, Ned O., 1001 Georges rd., New Bruns. (12)
 Boyd, Robert P., 120 Martine av., So. Fanwood (20)
 Boyer, Charles G., Annandale (10)
 Boyer, Paul K., 129 Summit av., Summit (20)
 Boyes, James G., 1326 Chetwynd av., Plainfield (20)
 Boylan, Lawrence B., 630 Main st., Paterson (16)
 Boyle, Francis L., 829 Boulevard, Bayonne (9)
 Boysen, Theo. H., 100 Philad'lphia st., Egg H'rbr. C'y (1)
 Brackett, Elizabeth R., 371 Franklin av., Nutley (7)
 Bradasch, George A., 1415 Central av., Union C'y (9)
 Bradford, Stella S., 16 Seymour st., Montclair (7)
 Bradley, Robert A., 1616 Pacific av., Atlantic City (1)
 Bradshaw, John H., 27 High st., Orange (7)
 Brady, Thomas S., 678 Ave. C, Bayonne (9)
 Brady, William A., 412 44th st., Union City (9)
 Braitman, Max, 412 60th st., West New York (9)
 Brakeley, Elizabeth, 71 Myrtle av., Montclair (7)
 Bramble, Halsey S., Front & Chestnut sts., Elmer (17)
 Brancato, Peter, 17 Church st., Paterson (16)
 Branch, W. Harold, 190 Duncan av., Jersey City (9)
 Brandenburg, Leo W., 2802 Blvd., Union City (9)
 Brandman, Otto, 83 Johnson av., Newark (7)
 Branin, Howard S., 200 W. Main st., Millville (6)
 Branon, Mark E., 16 W. Passaic av., Rutherford (2)
 Brasefield, Edgar N., 218 Chamber st., Phil'psb'g (21)
 Brauer, Selig L., 234 Bergen av., Jersey City (9)
 Braun, David C., 216 Spring st., Newton (19)
 Braun, Gustav A., 221 S. Orange av., Newark (7)
 Braun, Wm., 4307 W. Maple av., Merchantville (4)
 Braunstein, Sigmund C., 424 13th st., W. New Y'k (9)
 Braunstein, Wm. P., 1 Bellevue st., Weehawken (9)
 Bray, William E., 41 Elizabeth st., Pemberton (3)
 Bregman, Alexander, 2 Dempsey av., Edgewater (2)
 Breitstadt, Chas. A., 563 Summer av., Newark (7)
 Brennan, Alfred T. V., Jr., 275 Engle st., Englew'd (2)
 Brennan, Chas. L. S., 14 S. Br'dw'y, Gloucester C'y (4)
 Brennan, John P., 429 Cooper st., Camden (4)
 Brennock, Thos. McG., 3 Webster av., Jersey C'y (9)
 Breslow, Alexander E., 930 Pierpont st., Rahway (20)
 Breslow, Samuel, 157 Market st., Perth Amboy (12)
 Brethwaite, Sam'l H., Jr., 129 Summit av., Summit (20)
 *Brevoort, Henry H., 54 Main st., Lodi (16)
 Brick, George J., 43 Cottage st., Jersey City (9)
 Brien, William M., 449 Main st., Orange (7)
 Briggs, Henry, 144 Harrison st., East Orange (7)
 Brim, Anne S., Hotel Edgemere, East Orange (7)
 Brindle, Harry R., 501 Grand av., Asbury Park (13)
 Brittain, Elmore G., 4 E. High st., Bound Brook (18)
 Broadnax, Mary E., 140 Roseville av., Newark (7)
 Brodtkin, Eva T., 365 Osborne ter., Newark (7)
 Brody, Morton S., 67 Paterson st., New Bruns'k (12)
 Brogan, Francis B., 84 Ward st., Paterson (16)
 Brokaw, Christopher A., 1405 North av., Eliz'b'h (20)
 Bromberg, Chas. B., 107 Lexington av., Passaic (16)
 Brooks, George M., Cape May Court House (5)
 Brooks, Sidney S., 380 12th av., Paterson (16)
 Brophy, Francis X., 55 Gifford av., Jersey City (9)
 Broselow, Benjamin G., Delsea dr., Franklinville (8)
 Brotman, Morton M., 90 Avon av., Newark (7)
 Brown, Chester R., 22 Midland av., Arlington (7)
 Brown, Chester T., Prudential Ins. Co., Newark (7)
 Brown, Edith L., 332 Woodland av., Avon (13)
 Brown, Edward V., 9 Park av., Caldwell (7)
 Brown, Fred'k L., 67 Liv'gst'n av., New Bruns'k (12)
 Brown, Harvey S., 5 Club pl., Freehold (13)
 Brown, J. Carlisle, 101 S. Indiana av., Atl. City (1)
 Brown, John L., 647 Anderson av., Grantwood (2)
 Brown, Kenneth G., 501 Grand av., Asbury Park (13)
 Brown, L. Greeley, 173 Madison av., Elizabeth (20)
 Brown, Leonard, 190 Park st., Ridgefield Park (2)
 Brown, Lewis W., 160 Roseville av., Newark (7)
 Brown, Richard J., 105 Ridgewood rd., S. Orange (7)
 Brown, Stanley L., Glen av., Laurel Springs (4)
 Brown, Wm. H., 29 3rd st., Elizabeth (20)
 Browning, W. Kempton, 120 N. Centre st., M'r'ch'tv'le (4)
 Browning, Wm. J., 134 N. Centre st., Merch'tv'le (4)

- Brozdowski, John J., 554½ Jersey av., Jersey C'y (9)
 Bruning, Richard H., 372 Wyoming av., Maplew'd (7)
 Buchanan, Ralph M. L., 8 Market st., Phil'psb'g (21)
 Buckley, Jeremiah L., 666 Franklin av., Nutley (7)
 Buckley, Paul J., 159 Palisade av., Bogota (2)
 Buckley, Rich'd T., Jr., Peddie Sch'l, Hightst'n (11)
 Budd, J. Reuben, 379 Clifton av., Clifton (16)
 Budington, Walter I., 24 Commerce st., Newark (7)
 Buermann, Robert, 206 Madison av., Lakewood (15)
 Bugbee, Frederick C., 802 E. 5th st., Tucson, Ariz. (7)
 Bull, Louis M., 92 Heller Parkway, Newark (7)
 Bull, Robert I., 361 Lafayette st., Newark (7)
 Bull, William J., 98 Park st., Montclair (7)
 Bullen, Victor E., 148 Hamilton av., Paterson (16)
 Bullwinkel, Fred'k, Ocean Blvd., Atl. Highlands (13)
 Bump, Samuel C., 65 N. Maple av., Ridgewood (2)
 Bunnell, Fred'k N., 22 S. Main st., Barnegat (15)
 Burbidge, J. Raym'd, Is'bella McCosh Inf., Pr'nct'n (11)
 Burke, Leonard P., 30 Lakeside av., Verona (7)
 Burke, Stephen E., 212 First av., Newark (7)
 Burkett, J. Paul, 215 Delaware st., Woodbury (8)
 Burkett, Wendell J., 16 W. Holly av., Pitman (8)
 Burn, Victor E., 27 Trinity st., Newton (19)
 Burne, John J., 17 Gould av., Newark (7)
 Burnett, Chas. B., 109 Main st., South River (12)
 Burnham, Lyman, 229 Engle st., Englewood (2)
 Burns, Geoffrey C. H., County rd., Demarest (2)
 Burns, Joseph R., 46 S. Olden av., Trenton (11)
 Burns, Wilmer F., 267 White Horse Pike, Audubon (4)
 Burpeau, Wm. P., 1538 E. West Hgy., Silver Spgs., Md. (7)
 Burrill, Benj. B., Jr., 303 Montgomery st., Bl'mf'd (7)
 Burritt, Norman W., 30 Beechwood rd., Summit (20)
 Burroughs, Edmund W., 701 W. State st., Trenton (11)
 Burstein, Frank, 402 Clinton av., Newark (7)
 Busansky, Samuel T., Circle drive, Browns Mills (3)
 Busch, Herman, 38 Johnson av., Newark (7)
 Bush, Archer C., 40 Union st., Montclair (7)
 Bush, Ralph K., 131 E. Park av., Merchantville (4)
 Busico, Philip S., 131 Liberty rd., Englewood (2)
 Butcher, Charles, Heislerville (6)
 Butenas, Joseph J., 300 First av., Elizabeth (20)
 Butler, Eustace C., 249 Bloomfield av., Caldwell (7)
 Butler, Vincent P., 33 Bentley av., Jersey City (9)
 Butterfield, Arey A., 135 Aycrigg av., Passaic (16)
 Buvinger, Chas. W., 50 Washington st., E. Orange (7)
 Buzby, B. Franklin, 414 Cooper st., Camden (4)
 Byck, Louis, 794 S. 11th st., Newark (7)
 Byer, M. Yale, 827 E. State st., Trenton (11)
 Byers, Clarence W., 176 Union av., Rutherford (2)
 Byrne, J. Arthur, 16 Elhn st., Morristown (14)
 Bythewood, Alton E., Jr., 145 W. Market st., New'k (7)

ASSOCIATE MEMBERS

- Baime, Jules E., 41 Renner av., Newark (7)
 Balsamo, Joseph J., 314 Bergen st., Newark (7)
 Barbella, Joseph D., 498 N. 13th st., Newark (7)
 Barlow, John D., 194 Stockton st., Hightstown (11)
 Baxt, Sidney J., 544 21st av., Paterson (16)
 Bender, Louis, 284 Ridgewood av., Newark (7)
 Bennett, Robert E., N. J. State Hosp., Trenton (11)
 Bergsma, Daniel, 1 W. State st., Trenton (11)
 Berry, Leonard M., 205 Nassau st., Princeton (11)
 Binder, Israel L., 173 Lafayette st., Newark (7)
 Blake, Albert J., 423 Broadway, Paterson (16)
 Butan, Louis, 579 Valley rd., West Orange (7)

C

ACTIVE MEMBERS

- Cacciarelli, Robt. A., 517 Roseville av., Newark (7)
 Caggiano, Anthony P., 237 Grove st., Montclair (7)
 Caggiano, John D., 165 W. Main st., Pennsgrove (17)
 Cahill, Laurence A., 361 Lafayette st., Newark (7)
 Calabrese, D. John, 139 Rochelle av., Rochelle P'k (2)
 Caldwell, Donald M., Prudential Ins. Co., Newark (7)
 Callahan, Edward J., 124 St. Paul st., Westfield (20)
 Callery, Wm. T., 10 Columbia ter., Weehawken (9)
 Calligaro, Egildo A., 75 Clifton av., Clifton (16)
 Calvert, Wm. C., 225 Gregory av., West Orange (7)
 Calvin, Chas. H., 80 Commerce st., Perth Amboy (12)
 Camche, Leo J., 250 Renner av., Newark (7)
 Cameron, Arthur E., 59 Somerset st., Newark (7)
 Cameron, C. Paul, 401 Atlantic av., Ocean City (5)
 Cameron, Edwin A., 186 S. Burnett st., E. Orange (7)
 Campbell, James M., 101 S. Central av., Ramsey (2)
 Campbell, William, 144 Harrison st., East Orange (7)
 Campbell, Wm. K., 96 Third av., Long Branch (13)
 Campo, A. Guy, 200 Broadway, Westville (8)
 Candio, Vincent P., 347 Ridge rd., Lyndhurst (2)
 Cannon, Edward A., 7512 Hudson Blvd., N. Bergen (9)
 Canright, Cyril M., 34 Springfield av., Cranford (20)
 Cantini, Raphael S., 147 E. 7th st., Plainfield (20)
 Captainian, Aram A., 154 Main st., Matawan (13)
 Caputo, Anthony R., 217 Belleville av., Belleville (7)
 Carabelli, A. Albert, 306 Hamilton av., Trenton (11)
 Carberry, Edward T., 83 S. Main st., Wharton (14)
 Carbone, Francesco N., 440 Central av., Orange (7)
 Carbone, Ralph, 501 Marlboro rd., Wood-Ridge (2)
 Card, Chas. F., 144 W. Milton av., Rahway (20)
 Cardwell, Edgar P., 47 Central av., Newark (7)
 Carey, David S., 11 E. Main st., Freehold (13)
 Caridi, Salvatore, 5135 Bergenline av., W. New York (9)
 Carlander, Oswald R., 1972 Br'wning rd., M'r'ch'tv'le (4)
 Carlisle, J. Mallory, 550 Hillcrest av., Westfield (20)
 Carlisle, John H., 129 Prospect st., Passaic (16)
 Carlisle, Paul E., 763 Broad st., Newark (7)
 Carlough, David J., 426 Ellison st., Paterson (16)
 Carman, Fletcher F., 31 Lincoln Park, Newark (7)
 Carman, John H., 602 Crescent av., Plainfield (20)
 Carmona, L. Roberto, 141 Wood st., Tuckerton (15)
 Carpenter, Cedric C., 129 Summit av., Summit (20)
 Carpenter, Charles A., 10 N. Ridgew'd rd., S. Orange (7)
 Carpenter, Wm. H., 39 Aberdeen pl., Woodbury (8)
 Carr, Mary B., 1 Astor pl., Jersey City (9)
 Carrigan, Francis P., 305 Roseville av., Newark (7)
 Carrington, Wm. J., 905 Pacific av., Atlantic C'y (1)
 Carrol, Wilfred, 51 Ingraham pl., Newark (7)
 Carroll, C. Walter, 125 Centre st., Trenton (11)
 Carroll, Thos. R., 754 Anderson av., Cliffside Park (2)
 Carroll, William V., 211 Academy st., Trenton (11)
 Carsley, Sidney H., 19 Holly st., Cranford (20)
 Carter, Joseph F. S., 142 Atkins av., Asbury P'k (13)
 Cartnick, Louis C., 228 Hillcrest av., W'd-Ridge (2)
 Casuso, Paul F., 196 Hackensack st., Wood-Ridge (2)
 Casagrande, Stephen R., 600 7th av., Belmar (13)
 Casale, John B., 359 Bloomfield av., Newark (7)
 Casciano, Adolph D., 42 Ridgfield av., Ridg'd P'k (2)
 Casilli, Arturo R., 618 Newark av., Elizabeth (20)
 Casselman, Arthur J., 301 N. 2nd st., Camden (4)
 Cassidy, John M., 1913 Hudson Blvd., Jersey City (9)
 Castellano, Martin G., Essex Mt. Sana., Verona (7)
 Catanzaro, Francesco, 151 Jefferson st., Passaic (16)
 Cater, Douglas A., 57 S. Harrison st., E. Orange (7)

- Cella, Charles F., 359 Hamilton av., Trenton (11)
 Cerone, Daniel M., 309 First av., Newark (7)
 Cestone, Canio, 521 Pompton av., Cedar Grove (7)
 Cetrulo, Gerald I., 234 Mt. Prospect ave., Newark (7)
 Chaiken, Louis H., 1024 E. Jersey av., Elizabeth (20)
 Chalfant, W. Paxson, Jr., 7003 Ventnor av., Ventnor (1)
 Chalfant, Wm. P., Br'dwy & Crafton av., Pitman (8)
 Chamberlain, Aims R., 30 Lenox pl., Maplewood (7)
 Chamberlain, Richard R., 30 Lenox pl., Maplewood (7)
 Champlin, Paul M., 43 S. Arlington av., E. Orange (7)
 Chapman, Ellis J., 203 Danforth av., Jersey City (9)
 Chapman, Otis P., 125 Broad st., Elizabeth (20)
 Chapman, Robt. W., Ward H'm'st'd, Boy'dn av., Nwk. (7)
 Chapman, Walter I., 125 McKinley av., Hawthorne (16)
 Chapnick, Maurice M., 117 Paterson st., Paterson (16)
 Charbonneau, Eugene G., 111 S. Harrison st., E. Or. (7)
 Charleroy, Durant K., 38 Crosswicks st., Bordent'n (11)
 Charlton, C. Coulter, 124 S. Illinois av., Atl. City (1)
 Chase, Kalman, Jr., 80 Sheridan av., Hoboken (2)
 Chase, Wm. E., 137 Gregory av., Passaic (16)
 Chayes, Sydney, 980 Ave. C, Bayonne (9)
 Cherashore, Harry N., 363 Centre st., Nutley (7)
 Cherry, Homer H., Valley View Sana., Paterson (16)
 Chesler, Maurice, 124 W. Broadway, Salem (17)
 Chesner, William A., 1111 Hamilton av., Trenton (11)
 Chester, Saul W., 634 Broadway, Paterson (16)
 Chianese, C. Chester, 464 Hamilton av., Trenton (11)
 Chiger, Alexander S., 621 High st., Newark (7)
 Childers, Robert J., 604 Park av., Plainfield (20)
 Chilton, Forrest S., Nwk.-Pmptn. Tpk., Pmptn. Pl. (16)
 Chimacoff, Hyman, 171 Elizabeth av., Newark (7)
 Chipley, Bascomb L., Valley View Sana., Paterson (16)
 Chmelnik, Abraham G., 299 Clinton av., Newark (7)
 Chodosh, Maurice A., 606 Roosevelt av., Carteret (20)
 Christman, Irving, 408 Ellison st., Paterson (16)
 Christensen, Alexander H., Lebanon (10)
 Christensen, Osborne D., 326 Madis'n av., Hasb'k Hts. (2)
 Christian, Albion C., 1080 Clinton av., Irvington (7)
 Church, Franklin H., 86 W. Broadway, Salem (17)
 Ciampa, Ralph P. E., 383 Bath av., Long Branch (13)
 Ciccone, Anthony C., 389 Grand st., Paterson (16)
 Cieri, Daniel S., 1515 Central av., Union City (9)
 Ciliberti, Frank J., Jr., 713 S. 5th st., Camden (4)
 Clarie, D'Arcy C., 558 Broad av., Ridgefield (2)
 Clark, Alice L., 206 W. State st., Trenton (11)
 Clark, Charles C., 461 New York av., Union City (9)
 Clark, Chas. E., N. J. State Hospital, Trenton (11)
 Clark, Ernest W., 209 Haddon av., Westmont (4)
 Clark, Frank G., White House Station (10)
 Clark, J. Henry, 108 Orange road, Montclair (7)
 Clark, John C., 501 Grand av., Asbury Park (13)
 Clark, S. Worth, 152 So. No. Carolina av., Atl. City (1)
 Clarke, Edw. W., 435 Warwick av., W. Englew'd (2)
 Clarke, Francis M., 116 New st., New Brunswick (12)
 Clarcken, Joseph A., 30 Van Ness pl., Newark (7)
 Claus, C. Hermann, 776 S. 19th st., Newark (7)
 Clay, Thomas A., 351 Totowa av., Paterson (16)
 Cleary, Joseph P., Minotola (1)
 Clement, Baxter L., 31 Lincoln Park, Newark (7)
 Clock, Ralph O., 20 Ridgecrest W., Scarsdale, N.Y. (2)
 Close, Byron H., Hamburg Tnpk., Bloomingdale (16)
 Cloud, Albert W., Hugenot av., Englewood (2)
 Coburn, J. Wesley, 111 N. Oraton Pkwy., E. Orange (7)
 Cochrane, Cleland D., Main st., Closter (2)
 Coe, Richard, 156 Clinton av., Newark (7)
 Coffin, Henry F., 116 N. 9th st., Newark (7)
 Cogan, Henry, 616 Tacoma av., Buffalo, N. Y. (16)
 Coghlan, Jasper, 540 Parker st., Newark (7)
 Cohan, Charles C., 217 W. Hanover st., Trenton (11)
 Cohen, Harry X., 1 Garden dr., Roselle (20)
 Cohen, Herman, 489 Jersey av., Jersey City (9)
 Cohen, Herman, 1301 Hamilton av., Trenton (11)
 Cohen, Herman N., 714 Park av., Hoboken (9)
 Cohen, I. Elvin, 561 Elizabeth av., Newark (7)
 Cohen, Julian, 475 Park av., Paterson (16)
 Cohen, Louis, 257 Paulison av., Passaic (16)
 Cohen, M. Marvin, 137 Graham av., Paterson (16)
 Cohen, Maurice, 196 Valley rd., Montclair (7)
 Cohen, Maurice B., Woolworth Bldg., Wildwood (5)
 Cohen, Max, 60 Ridge rd., N. Arlington (7)
 Cohen, Meyer J., 118 Johnson av., Newark (7)
 Cohen, Nathan B., 232 State st., Perth Amboy (12)
 Cohen, Oscar H., 115 Church st., Boonton (14)
 Cohen, Paul, 500 State st., Camden (4)
 Cohen, Samuel, 343 Fairmount av., Jersey City (9)
 Cohen, Samuel A., 477 Jersey av., Jersey City (9)
 Cohen, Sidney A., 283 Clinton pl., Newark (7)
 Cohen, Sidney L., 20 Avon av., Newark (7)
 Cohen, Sidney P., 512 Franklin av., Nutley (7)
 Cohen, William, 1007 Greenwood av., Trenton (11)
 Cohn, George M., 748 S. 10th st., Newark (7)
 Cohn, Hermann, 393 Clinton av., Newark (7)
 Cohn, Isidor, 231 Lexington av., Passaic (16)
 Cohn, Royal M., 740 Clinton av., Newark (7)
 Colavita, James J., 433 Princeton av., Trenton (11)
 Colby, Maxwell X., 133 Chelsea av., Long Branch (13)
 Cole, L. Frank, 242 Broadway, Passaic (16)
 Cole, Walter H., Jr., 1060 E. Jersey st., Elizabeth (20)
 Coleman, Austin H., Clinton (10)
 Coleman, Joseph G., Hamburg (19)
 Coleman, Russell M., 54 N. Clinton st., E. Orange (7)
 Collier, Martin H., Camd'n Co. T.B. Hosp., Lakeland (4)
 Collins, Henry J., 1160 Hamilton av., Trenton (11)
 Collins, Laurence M., N.J. State Hosp., Gr'yst'ne Pk (14)
 Collins, Louis K., 54 State st., Glassboro (8)
 Colmer, M. Jonas, 31 Lincoln Park, Newark (7)
 Colsh, LeRoy L., 612 Ridgewood rd., Maplewood (7)
 Colton, Ethan T., Jr., 31 Park st., Montclair (7)
 Comando, Harry N., 690 Clinton av., Newark (7)
 Comeau, George W., 415 Speedwell av., Morris Pls. (14)
 Comfort, John B., 50 S. Clinton av., Trenton (11)
 Communi, Frank F., 513 Bridge st., Trenton (11)
 Comora, Herman C., 317 60th st., W. New York (9)
 Comunale, Anthony R., 1709 Irving st., Rahway (20)
 Conaway, Walt P., 1723 Pacific av., Atlantic City (1)
 Connamacher, Harold S., 671 Spring'd av., N'w'rk (7)
 Connell, Emmet J., 2227 Boulevard, Jersey City (9)
 Connell, John N., 26 Carlton av., Jersey City (9)
 Connelly, John A., 212 W. State st., Trenton (11)
 Connolly, John J., 180 Ballantine Pkwy., Newark (7)
 Connolly, Joseph P., 64 Hamilton st., Paterson (16)
 Connolly, Richard N., 117 5th st., Newark (7)
 Connolly, T. Vincent, 56 Hamilton st., Paterson (16)
 Connolly, Thos. W., 921 Bergen av., Jersey City (9)
 Connor, Clarence A., 1586 Center av., Fort Lee (2)
 Conroy, John S., 122 E. Broad st., Burlington (3)
 Conserva, Peter V., 215 Dayton av., Clifton (16)
 Conty, Anthony J., 318 48th st., Union City (9)
 Conway, James V., 428 Elmora av., Elizabeth (20)
 Cook, Hugh F., 21 Roseville av., Newark (7)
 Cooke, H. Hamilton, 100 Prospect st., Ridgew'd (2)
 Cooke, Wm. H., 303 Main st., East Orange (7)
 Cooley, Justus H., II, 3 W. Union av., Bound Br'k (18)
 Cooper, Irving J., 116 Livingston av., New Bruns. (12)
 Cooper, J. Howard, East Millstone (18)
 Cooper, Jules, Washington st., Woodbine (5)
 Cooperman, William, 647 Market st., Newark (7)
 Copleman, Benjamin, 263 High st., P'th Amboy (12)
 Copleman, Hyman B., 111 Liv'gst'n av., N'w Brns. (12)
 Coplin, George J., 510 E. Jersey st., Elizabeth (20)
 Corbusier, Harold D., 612 Park av., Plainfield (20)
 Cordasco, Peter, 24 Dodd st., Bloomfield (7)
 Corio, George A., 307 S. Clinton av., Trenton (11)
 Corn, David, 119 Park st., Ridgefield Park (2)
 Cornish, Chas. H., 673 Prospect st., Maplewood (7)
 Cornwell, Alfred, 265 N. Laurel st., Bridgeton (6)
 Corrigan, Patrick H., 1720 S. Broad st., Trenton (11)
 Corson, Allen, 824 Wesley av., Ocean City (5)
 Corson, Filbert R., 101 S. Indiana av., Atlantic City (1)
 Corson, Kenneth E., 25 S. Myrtle st., Vineland (6)

- Cortese, Alvin E., 26 Ward st., Paterson (16)
 Cosgrove, Samuel A., 254 Union st., Jersey City (9)
 Costabile, Vincent, 150 Ridge rd., Lyndhurst (2)
 Costello, Wm. F., 55 W. Blackwell st., Dover (14)
 Cotton, Henry A., Jr., N. J. State Hosp., Trenton (11)
 Cotton, Norman T., 219 Graham av., Paterson (16)
 Cottone, Rosario J., 683 Princeton av., Trenton (11)
 Cottrell, Judson G., 159 Market st., Perth Amboy (12)
 Coughlan, Ella A., 10 Oakwood av., Orange (7)
 Coughlin, Frank J., 100 Magnolia av., Arlington (7)
 Coughlin, John P., 160 Wegman Pkwy., Jersey City (9)
 Coughlin, Joseph J., 840 Queen Ann rd., Teaneck (2)
 Coultas, Aldo B., 1 Madison av., Madison (14)
 Coward, Edwin H., Box 666, Pleasantville (1)
 Cowlbeck, Harry D., 224 W. State st., Trenton (11)
 Cox, Harold C., 208 Stockton st., Hightstown (11)
 Cox, John C., 55 Woodland rd., Maplewood (7)
 Cox, Wm. W., 79 S. Fullerton av., Montclair (7)
 Coxson, Harold P., Laurel rd., Stratford (4)
 Crabtree, Loren H., 142 Bellevue st., Elizabeth (20)
 Cracco, Frederick A., 211 Palisade av., Union City (9)
 Craig, Henry A., 315 William st., Somerville (18)
 Crain, William E., 406 Cooper st., Woodbury (8)
 Crandall, John K., 200 Main st., Fort Lee (2)
 Crandell, Archie, N. J. State Hosp., Greystone Pk (14)
 Crane, Bernard, 306 Pacific av., Atlantic City (1)
 Crane, Charles G., 78 Farley av., Newark (7)
 Crane, Norman T., 147 E. 7th st., Plainfield (20)
 Crapanzano, Domenico, Essex Co. Hosp., Cedar Gr. (7)
 Crawford, Georgina U., 28 Carnegie av., E. Orange (7)
 Crawford, John W., Main st., Bedminster (18)
 Crecca, Anthony D., 76 2nd st., Newark (7)
 Crecca, William D., 111 Park av., Newark (7)
 Cregar, John S., 150 Harrison st., East Orange (7)
 Cremens, John F., 144 Carroll st., Paterson (16)
 Crescente, Fred J., 827 Madison av., Paterson (16)
 Crist, Walter A., 725 Collings av., W. Collingswood (4)
 Cronin, Francis J., 730 South st., Elizabeth (20)
 Crooks, William J., III, Glen Gardner (10)
 Cropsey, Chas. D., 168 Chestnut st., Rutherford (2)
 Crossfield, Henry C., 144 Harrison st., E. Orange (7)
 Crounse, David R., 84 Broadway, Passaic (16)
 Crowe, Aldrich C., 735 Atlantic av., Ocean City (5)
 Crowley, Leo F., 148 Belmont av., Jersey City (9)
 Cryder, Millard C., Cape May Court House (5)
 Crystell, Edward H., 4 Hawthorne av., Nutley (7)
 Csema, Emery J., 151 Somerset st., New Brunswick (12)
 Ctibor, Vladimir F., Califon (10)
 Cufari, Carmine J., 725 18th st., Union City (9)
 Culver, S. Herbert, 75 Magnolia av., Jersey City (9)
 Cummins, Geo. W., 202 Mansfield st., Belvidere (21)
 Cunningham, Chas., 7th and Wood sts., Vineland (6)
 Cunningham, Joel B., 801 Cooper st., Camden (4)
 Currie, Norman W., 508 Central av., Plainfield (20)
 Curry, Marcus A., N. J. State Hosp., Greystone Pk (14)
 Curtis, A. Maurice, 445 Van Houten st., Paterson (16)
 Curtis, Donald A., 241 Union st., Hackensack (2)
 Curtis, Elbert A., 65 Central av., Newark (7)
 Curtis, Howard C., 224 E. Main st., Moorestown (3)

ASSOCIATE MEMBERS

- Catalupo, Emidio, 95 Nichols st., Newark (7)
 Cantelmo, Alphonse L., 207 S. Harrison st., E. Orange (7)
 Charney, William, 647 Broadway, Paterson (16)
 Christoph, Francis T., 10 N. Ridgewood rd., S. Orange (7)
 Cilla, J. Philip, Toms River (15)
 Ciuccarelli, Francesco, 225 Hamilton av., Trenton (11)
 Clark, Orol H., 149 Prospect st., Passaic (16)
 Clunan, Ambrose P., Fort Dix (11)
 Conti, Horace, 229 Kearny av., Kearny (7)
 Cooperman, Eli L., 527 N. Brunswick av., Fords (12)
 Covino, Louis L., 44 Oakland ter., Newark (7)

D

ACTIVE MEMBERS

- D'Acerno, Pellegrino A., 346 Plisde av., Union City (9)
 D'Agostin, Henry, 243 Fulton ter., Cliffside Park (2)
 D'Agostini, Alfred J., 41 Columbia av., Newark (7)
 Dalberg, Walter, 500 Cherry st., Elizabeth (20)
 D'Alessandro, Arthur J., 15 Salem st., Newark (7)
 Daly, Edmund J., 921 Bergen av., Jersey City (9)
 D'Amato, Chas. R., 324 Hoboken rd., E. Rutherford (2)
 D'Ambola, Philip R., 21 S. 6th st., Harrison (7)
 Dandois, Geo. F., 220 E. Wildwood av., Wildwood (5)
 Dane, Charles, 61 Scotland rd., South Orange (7)
 Dane, John, 61 Scotland rd., South Orange (7)
 D'Angelo, Jos. C., 330 Washington av., Belleville (7)
 Danielson, John J., 4703 Tonnele av., N. Bergen (9)
 Danzis, Maximillian, 31 Lincoln Park, Newark (7)
 Darby, C. Eugene, Plymouth & Atl. avs., Ocean City (5)
 D'Arcy, Walter E., 545 E. State st., Trenton (11)
 Darden, Walter T., 149 W. Kinney st., Newark (7)
 Darlington, Emlen P., New Lisbon (3)
 Daron, Simeon, 31 Lincoln Park, Newark (7)
 Davenport, Irwin P., 545 W. State st., Trenton (11)
 Davenport, Peter B., 764 S. Orange av., Newark (7)
 Davey, Thomas N., 41 W. 33rd st., Bayonne (9)
 Davidson, E. Norwell, 102 E. Elm st., Linden (20)
 Davidson, Harold S., 101 S. Indiana av., Atl. City (1)
 Davidson, Henry A., 31 Lincoln Park, Newark (7)
 Davidson, Louis L., 31 Lincoln Park, Newark (7)
 Davidson, Maurice M., 128 Grant av., E. Roseton Pk (20)
 Davies, George A., 53 Front st., Elmer (6)
 Davies, George W., 35 Fairview av., Verona (7)
 Davis, A. Hobson, Paterson Gen. Hosp., Paterson (16)
 Davis, Albert B., 511 Cooper st., Camden (4)
 Davis, Daniel, 14 Webster av., Jersey City (9)
 Davis, E. Vernon, 63 Mill st., Vincentown (3)
 Davis, F. Cleveland, 129 Summit av., Summit (20)
 Davis, Harold L., 178 W. State st., Trenton (11)
 Davis, J. Stannard, 350 Kings Hwy., E. Haddonfield (4)
 Davis, Jacob M., 1400 High st., Burlington (3)
 Davis, James T., 1169 Elizabeth av., Elizabeth (20)
 Davis, John E., Jr., N. J. State Hosp., Trenton (11)
 Davis, Louis, 825 S. 10th st., Newark (7)
 Davis, Stanton H., 212 E. 7th st., Plainfield (20)
 Davis, Thomas C., 30 Old Short Hills rd., Millburn (7)
 Davis, W. Cole, 109 S. Portland av., Ventnor (1)
 Davison, C. Spencer, 7 Chestnut st., Salem (17)
 Davison, Royden W., 205 W. State st., Trenton (11)
 Davison, Wilbur S., 13 N. Broadway, Pennsville (17)
 Dawson, Harry, 618 E. 24th st., Paterson (16)
 Day, Grafton E., Frazer & N. J. avs., Collingswood (4)
 Day, Hayward F., 37 Craig pl., N. Plainfield (18)
 Day, Samuel T., Main st., Port Norris (6)
 Day, Willis B., 407 E. 7th st., Plainfield (20)
 Dayton, Spencer T., 86 W. Demarest av., Englewood (2)
 Dean, Guy K., Jr., Princeton rd., Plainsboro (11)
 DeBell, Peter J., 65 Summer st., Passaic (16)
 DeCesare, Ferdinand J., 500 Walnut st., Roseton Pk (20)
 Decker, Charles T., 275 Orchard st., Westfield (20)

- Decker, Henry B., 527 Penn st., Camden (4)
Decker, John G., 216 Blvd., Hasbrouck Heights (2)
DeFelice, Mario T., 28 Mt. Airy rd., Bernardsville (14)
DeFronzo, Morando, 180 Fairmount av., Newark (7)
DeFuccio, Chas. P., 12 Duncan av., Jersey City (9)
Degenhardt, Ira H., 51 Livingston av., NewBrun. (12)
DeGrace, Francis H., 344 Gregory av., Passaic (16)
deHellenbranth, R. T., 104 S. Frankfort av., V'ntn'r (1)
Deibert, Irvin E., 538 Cooper st., Camden (4)
Deibert, Kirk R., 159 Elm av., Woodlynne (4)
Deich, Samuel R., 162 Lexington av., Passaic (16)
Deichman, Charles H., 39 Elm st., Morristown (14)
Deignan, William L., 257 Dodd st., E. Orange (7)
Deitz, Joseph R., 320 Centre st., Trenton (11)
Delario, Anthony J., 294 Broadway, Paterson (16)
Del Deo, Nicholas V., 49 State st., Newark (7)
Del Duca, Vincent P., 527 Cooper st., Camden (4)
Del Guercio, Olindo, 365 Bloomfield av., Newark (7)
Della Penna, Sam'l J., 502 Ramapo av., Pmptn. Lks. (16)
Del Mauro, Alphonse, 460 Park av., Paterson (16)
DeMarco, Silverino V., 1818 Hudson Blvd., Jer. City (9)
Demarest, Gerald B., 531 E. Broad st., Westfield (20)
Demarest, J. Willis, 124 Elm av., Hackensack (2)
De Mattia, Michael, 71 Ward st., Paterson (16)
Dembinski, T. Henry, 1238 S. Clinton av., Trenton (11)
DeMeritt, Chas. L., 4622 Boulevard, Union City (9)
Dempsey, J. Harvey, Washington av., Berlin (4)
Denbo, Elic A., 854 Haddon av., Camden (4)
Denelsbeck, J. Otis, 878 E. State st., Trenton (11)
Denes, Oscar, 402 Centre st., Nutley (7)
Denig, Ralph D., 370 State st., Hackensack (2)
DePalma, Anthony F., 226 Roseville av., Newark (7)
DePhillips, Benedict R., 43 Park av., Newark (7)
dePons, Sarah C., 501 Grand av., Asbury Park (13)
DeRosa, Armand, 262 Totowa rd., Totowa (16)
DeRosa, John, 150 Fair st., Paterson (16)
DeRosa, Louis, Main av., Stirling (14)
Dershimer, Fred'k W., 22 Gifford av., Jersey City (9)
DeSantis, Orazio J., 100 N. 2nd st., Millville (6)
DeSanto, Anth'ny M., S'm't av. & Es's st., H'k'n's'k (2)
Desmet, Victor F., 324 Broadway, Paterson (16)
De Troia, Frederick C., 40 12th av., Newark (7)
Deuell, William D., 430 Union st., Hackensack (2)
Deutel, Oscar R., 283 Franklin st., Bloomfield (7)
Deutsch, Nathan S., 300 W. 7th st., Plainfield (20)
De Vincentis, Henry, 285 Henry st., Orange (7)
DeVita, Anthony J., Wilson av., Port Monmouth (13)
DeVivo, John A., 225 Littleton av., Newark (7)
Devlin, Hugh J., 72 Thomas st., Newark (7)
Dewis, Edwin G., 21 Westra st., Interlaken (13)
Dexter, Harriet E. T., 903 Ave. C, Bayonne (9)
DeYoe, Leon E., 602 Broadway, Paterson (16)
Dezer, Chas. N., Jr., 210 Main st., Hackensack (2)
Diamond, David I., Oceanport av., Oceanport (13)
Diamond, J. George, 512 W. Front st., Plainfield (20)
Dias, Joseph L., 17 Lombardy st., Newark (7)
Dickson, John D., 202 Larch av., Bogota (2)
Dickson, T. Bruce, 408 Main st., Riverton (3)
Dieffenbach, Richard H., 570 Mt. Pr'sp't av., Nwk. (7)
Dieker, Howard E., 78 Main st., South River (12)
DiFino, Felix J., 88 Jefferson st., Newark (7)
DiGiacomo, Harry E., 2 Prospect pl., Newark (7)
DiGiacomo, Wm. H., 223 Fairmount av., Newark (7)
Dilger, Frederick G., 210 Main st., Hackensack (2)
Dillingham, Willis I., 431 15th st., W. New York (9)
DiMarino, Anthony J., 735 Delaware st., Paulsboro (8)
Dimun, John T., 960 S. Broad st., Trenton (11)
Dinge, Ferdinand C., 67 S. Munn av., E. Orange (7)
Dingman, Norman M., 330 Broadway, Paterson (16)
DiNorcia, Joseph, 498 W. Market st., Newark (7)
Diskan, Samuel M., 1904 Pacific av., Atlantic City (1)
Diversity, Henry B., 38 Cooper st., Woodbury (8)
Dochtermann, Warren P., 532 Main st., Chatham (14)
Dodd, Edward L., 157 Forest st., Belleville (7)
Dodd, Wm. E., Ocean st. & Bay av., Beach Haven (15)
Dodge, James T., 1819 S. Broad st., Trenton (11)
Dodson, Louis W., 592 Jersey av., Jersey City (9)
Doggett, E. Hugh, 916 Park av., Plainfield (20)
Doktor, David, 288 Hamilton av., Paterson (16)
Dolsky, Irving, 509 N. Wood av., Linden (20)
Domine, Anthony Z., Blairstown (21)
Donahue, William J., 71 S. 9th st., Newark (7)
Donchi, Sol M., 9 Madison av., Newark (7)
Donnelly, Joseph E., 445 Market st., Paterson (16)
Donnelly, Jos. P., 58 Kensington av., Jersey City (9)
Donohoe, Lucius F., 140 W. Eighth st., Bayonne (9)
Donovan, Jos., N. J. State Hosp., Greystone P'k (14)
Doody, Wm. M., 19 Bentley av., Jersey City (9)
Doran, Ralph J., 200 11th st., Hoboken (9)
Doran, Wm. G., 2685 Boulevard, Jersey City (9)
Doranz, Harold K., 491 Centre st., Trenton (11)
Dorn, Elliott I., 267 Vassar av., Newark (7)
Dougherty, Daniel D., 1006 Garden st., Hoboken (9)
Douglass, Stephen A., Valley View Sana., Paters'n (16)
Douglass, Wm. C., 15 Olcott av., Bernardsville (18)
Dow, Robert F., 592 E. 29th st., Paterson (16)
Dowd, Ambrose F., 239 Broadway, Newark (7)
Downing, Perley E., Sedgwick st., Jamesburg (12)
Downs, Louis S., 141 Roosevelt av., Carteret (12)
Downs, Roscius I., 40 Scott st., Riverside (3)
Doyle, John J., 426 Fairmount av., Jersey City (9)
Draesel, Chas., 9027 Hudson Blvd., N. Bergen (9)
Dragonetti, Elvige N., 177 Clifton av., Newark (7)
Drake, Daniel E., Union Valley rd., Newfoundl'nd (16)
Drake, Leo B., 47 Main st., Franklin (19)
Drake, Paul F., 85 Summit av., Phillipsburg (21)
Dranow, Paul, 233 Franklin av., Nutley (7)
Drapkin, Berta, 31 Lincoln Park, Newark (7)
Dresel, Irmgard, Far Hills (21)
Dreskin, Jacob L., 172 Lyons av., Newark (7)
Drezner, Henry L., 507 S. Warren st., Trenton (11)
Driscoll, Chas. D., 6 White Horse Pk., Hadd'n Hts. (4)
Driscoll, Raymond S., 919 Boulevard, Bayonne (9)
Drossner, Jacob L., 1300 Park Blvd., Camden (4)
Drury, Alfred J., 268 E. 3rd av., Roselle (20)
DuBois, Morris G., 769 High st., Newark (7)
duBusc, L. C. Victor, 399 Westfield av., Elizabeth (20)
Dukes, Howard R., 220 Kearny av., Kearny (9)
Dulin, Everett V., 144 Harrison st., E. Orange (7)
Duncan, Owsley B., 606 E. 26th st., Paterson (16)
Dunham, Malcolm M., 88 Grove av., Woodbridge (12)
Dunn, H. Irving, 610 Salem av., Elizabeth (20)
Dunn, John S., 75 Market st., Salem (17)
Dunn, Theodore B., 35 Park pl., Bloomfield (7)
Dunning, Walter L., 533 River st., Paterson (16)
Durchlag, E. Nelson, 12 Myrtle av., Irvington (7)
Durham, Robert B., 130 S. Illinois av., Atlantic City (1)
Durham, Royal E., 100 S. New Haven av., Ventnor (1)
Durrh, Fred F., 310 Plainfield av., Plainfield (20)
Duvall, Albert I., N. J. State Hosp., Marlboro (13)
Dwyer, Leon C., 420 N. Wood av., Linden (20)
Dwyer, Henry E., 261 Madison av., Passaic (16)
Dwyer, Wm. A., 99 Park av., Paterson (16)

ASSOCIATE MEMBERS

- Dailey, Edward S., 485 Park av., Orange (7)
D'Amico, Thomas V., 16 Grove av., Verona (7)
De Gerome, James H., 10 Ridgew'd av., Glen Ridge (7)
Duschock, Edw. F., 188 Wash'gt'n av., Pth. Amb'y (12)
De Hart, George K., 132 Sunset av., Verona (7)
Dessauer, Joseph, 80 Clinton av., Newark (7)
Duffy, Edward P., Jr., 330 Wash'gt'n av., Belleville (7)

E

ACTIVE MEMBERS

- Eagleton, Wells P., 15 Lombardy st., Newark (7)
 Eames, Wm. N., 1871 Pennington rd., Trenton (11)
 Earp, Ruth, 15 Olcott av., Bernardsville (14)
 Eason, Samuel W., 48 DeForest av., Summit (20)
 East, Isaac C., State Home for Boys, Jamesburg (12)
 Eaton, Arthur T., 201 4th av., Haddon Heights (4)
 Ebenfeld, Samuel W., 344 High st., Newark (7)
 Ebner, Paul G., 719 Cooper st., Camden (4)
 Echikson, Joseph I., 31 Lincoln Park, Newark (7)
 Eckert, Walter L., College av., Haverford, Pa. (1)
 Eckhardt, Ralph A., 50 Green Village rd., Madison (14)
 Eddy, Lester R., 40 Bank st., Sussex (19)
 Edelberg, Sidney S., 403 E. High st., Bound Br'k (18)
 Edelen, James J., 280 S. Clinton st., East Orange (7)
 Edelson, Samuel, 1141 Corlies av., Neptune (13)
 Edgar, Jos. A., 71 Congress st., Jersey City (9)
 Edgar, Malcolm S., 129 Summit av., Summit (20)
 Edlkraut, Edward C., 129 Highland av., Passaic (16)
 Edwards, J. Bennett, 144 Woodridge pl., Leonia (2)
 Edwards, Lena F., 358 Pacific av., Jersey City (9)
 Ehrenfeld, Edward, 185 Lexington av., Passaic (16)
 Ehrenfeld, Irving, 185 Lexington av., Passaic (16)
 Ehrlich, Edward, 79 Shanley av., Newark (7)
 Ehrlich, Max, 379 Elmora av., Elizabeth (20)
 Ehrlich, William E., 31 Lincoln Park, Newark (7)
 Eichler, Bernard B., 221 Midland av., Montclair (7)
 Eigen, Louis A., 511 Valley rd., West Orange (7)
 Ein, William B., 31 Lincoln Park, Newark (7)
 Eisemann, Jerome S., Main st., Alloway (17)
 Eisenberg, David S., 31 Lincoln Park, Newark (7)
 Ekins, Frank P., 221 Broadway, Paterson (16)
 Elias, Elmer J., 474 Greenwood av., Trenton (11)
 Ellenson, Solomon S., 507 4th av., Asbury Park (13)
 Elliott, Frazier J., 10 N. Second st., Hammonton (1)
 Ellis, Alexander, 513 Broadway, Camden (4)
 Ellis, Arthur J., 282 Broad st., Newark (7)
 Ellis, Moury I., 177 S. Clinton av., E. Orange (7)
 Ellmers, Basil J., 230 New Milford av., N'w Milfd (2)
 Ely, Lancelot, 128 W. High st., Somerville (18)
 Emerson, Linn, 303 Park av., Orange (7)
 Emmer, S. Wolfe, 31 Lincoln Park, Newark (7)
 Engelhart, Ferdinand K., 701 St'ys't av., Tr'nt'n (11)
 English, Harrison F., III, N. J. St. Hosp., Tr'nt'n (11)
 English, John T., 110 Yale av., Irvington (7)
 English, Samuel B., N. J. State Hosp., Glen G'rdn'r (10)
 Enright, Jas. G., 25 Kensington av., Jersey City (9)
 Epler, Don A., 45 Hillside ave., Newark (7)
 Epstein, Harry B., 31 Lincoln Park, Newark (7)
 Epstein, Rubie, 606 Perry st., Trenton (11)
 Erber, Leonard B., 2703 Pacific av., Atlantic City (1)
 Erler, Eugene W., 360 Irving av., So. Orange (7)
 Ernest, Richard B., 240 W. State st., Trenton (11)
 Ervin, Millard B., 572 Prospect st., Maplewood (7)
 Esposito, Anthony L., 478 Clifton av., Clifton (16)
 Essertier, Edward P., 273 State st., Hackensack (2)
 Esty, Geoffrey W., 629 E. Broad st., Westfield (20)
 Etheridge, Chas. H., 433 Prospect st., E. Orange (7)
 Eulner, Elmer H., 216 Henry st., So. Amboy (12)
 Evans, Charles H., 144 Harrison st., E. Orange (7)
 Evans, David P., 144 Harison st., E. Orange (7)
 Evans, Edgar J., Hinchman av., Denville (14)
 Evans, J. Lawrence, 7117 Park av., Woodcliff (9)
 Evans, J. Lawr., Jr., 254 Christie H'ghts st., Leonia (2)
 Ewens, Arthur E., 3600 Pacific av., Atlantic City (1)
 Ewing, Harvey M., 31 Trinity pl., Montclair (7)
 Eynon, Harold K., 579 Haddon av., Collingswd (4)
 Eynon, James R., 700 Haddon av., Collingswood (4)

ASSOCIATE MEMBERS

- Erdman, George L., 142 Clinton av., Newark (7)

F

ACTIVE MEMBERS

- Fabian, Paul L., 520 Princeton av., Trenton (11)
 Facciolo, Francesco, 562 Boulevard, Bayonne (9)
 Fader, Ferdinand, 3 S. Grove st., East Orange (7)
 Fagan, James L., 51 Bayard st., New Brunswick (12)
 Fager, Rudolph O., 53 Park pl., Bloomfield (7)
 Fahrenbruch, Fred'k D., 101 Garden st., Mt. Holly (3)
 Failing, Brayton E., 31 Lincoln Park, Newark (7)
 Failmezger, Theodore R., 125 Green av., Madison (14)
 Fairbanks, Warren H., 27 Broadway, Freehold (13)
 Faison, John B., 45 Glenwood av., Jersey City (9)
 Falcone, Nicholas A., 68 Watchung av., N. Pl'nfd (18)
 Falkinburg, LeRoy W., Atl. C'y Blvd., Forked River (15)
 Fanburg, Sol J., 31 Lincoln Park, Newark (7)
 Fanelli, Antonio, 471 Laurie st., Perth Amboy (12)
 Farden, Joseph L., 342 Roseville av., Newark (7)
 Farkas, Gustav, 95 Jackson st., Passaic (16)
 Farkas, Morris, 163 High st., West Orange (7)
 Farmer, Vincent, 288 State st., Hackensack (2)
 Farmer, Walter D., 28 S. Main st., Allentown (11)
 Farr, Irving L., 214 Walnut st., Montclair (7)
 Farr, John C., 1111 Bloomfield st., Hoboken (9)
 Farr, Walter J., 288 Griggs av., Teaneck (2)
 Farrell, Edgar A. H., 25 Kings Hwy. W., Had'nfd (4)
 Fattel, Henry C., 8300 Hudson Blvd., N. Bergen (9)
 Faughnan, Rose C., 97 High st., Passaic (7)
 Faulkingham, Ralph J., 61 Liv-gst'n av., N'w Brns. (12)
 Fauquier, Leonard B., 172 Jewett av., Jersey City (9)
 Faux, Frederick J., 171 W. Center st., Woodbury (8)
 Fazio, Vincent J., 360 Main st., South Amboy (12)
 Featherston, Daniel F., 506 4th av., Asbury Park (13)
 Fechner, Fred J., 846 Garrison av., Teaneck (2)
 Fechner, Julius, 362 Clinton av., Newark (7)
 Federer, John J., 69 Columbia ter., Weehawken (9)
 Feher, Ladislav A. M., 177 Somers't st., N'w Brns. (12)
 Feigenoff, Israel, 665 Broadway, Paterson (16)
 Fein, Bernard, 585 Elizabeth av., Newark (7)
 Feinberg, Harry D., 384 2nd av., Long Branch (13)
 Feinstein, Louis, 410 Pacific av., Atlantic City (1)
 Feldman, Frank H., 115 Lyons av., Newark (7)
 Feldman, Joel, 81 Broad st., Eatontown (13)
 Feleppa, Edward E., 618 Springfield av., Summit (20)
 Felitti, Vincent J., 6 75th st., North Bergen (9)
 Fell, Alton S., Donnelly Mem. Hosp., Trenton (11)
 Feller, Wm., 283 Bergen av., Jersey City (9)
 Fellman, Morris, 907 Summit av., Jersey City (9)
 Feman, J. George, 141 Main st., Keansburg (13)
 Fendrick, Edward, 171 Watson av., E. Orange (7)
 Feneck, Chas. C., Univ. Hosp., Ann Arbor, Mich. (7)
 Fenimore, Edward D., 77 Grace st., Jersey City (9)
 Fenster, Morton N., 211 Lexington av., Passaic (16)

- Fenton, Tennant E., 320 Ludlow av., Spring Lk.(13)
 Ferguson, William E., 22 James st., Newark (7)
 Fermaglich, Harry B., 881 Garrison av., Teaneck (2)
 Fern, Samuel S., 122 Elizabeth av., Newark (7)
 Ferrari, Andrew F., 110Hackensack st.,E.R'th'rf'd(2)
 Ferrary, Paul B., 232 Totowa rd., Totowa Boro (16)
 Ferriss, Ruth B., 51 Maple av., Morristown (14)
 Fessler, A. James, 1544 S. Broad st., Trenton (11)
 Fessler, William, 31 Knox av., Grantwood (2)
 Fessman, John W., Clements Br. rd., Runnemede(4)
 Feuer, Joseph A., 654 Elm st., Arlington (7)
 Fewsmith, Joseph L., 120 Second av., Newark (7)
 Fialk, Harry, 4816 Hudson st., Union City (9)
 Ficke, Sylvia A., 884 Summit av., Jersey City (9)
 Fiedler, Michael J., 247 Crawford ter., Union (20)
 Field, Frank L., Far Hills (18)
 Fiering, Abraham M., Pmptn.TnPk,M'tainView(16)
 Fietti, Vincent G., 15 Ridge rd., Lyndhurst (2)
 Fifer, William T., 746 Ave. C, Bayonne (9)
 Filippone, Ames L., 149 Clifton av., Newark (7)
 Filkins, Cedric E., 418 White Horse Pk.,Audubon(4)
 Fine, Hyman P., 151 Market st., Perth Amboy (12)
 Fine, Irvin J., 256 State st., Perth Amboy (12)
 Fine, M. James, 65 Girard pl., Newark (7)
 Fine, Sydney G., 868 Stuyvesant av., Trenton (11)
 Fineberg, Bernard J., 113 Bentley av., Jersey City(9)
 Fineberg, Jacob C., 50 Glenwood av., Jersey City(9)
 Finegan, Paul J., 200 W. State st., Trenton (11)
 Finger, Frederick A., 938 Ave. C, Bayonne (9)
 Fink, Irving E., 129 Lyons av., Newark (7)
 Finke, Chas. H., 317 York st., Jersey City (9)
 Finke, George W., 237 State st., Hackensack (2)
 Finke, John H. D., 19 Hudson st., Hackensack (2)
 Finkel, Joshua, 368 Clinton av., Newark (7)
 Finkelstein, Abe S., 670 Clinton av., Newark (7)
 Finkle, Lester J., 225 Perry st., Trenton (11)
 Finkler, Rita S., 35 Leslie st., Newark (7)
 Finn, Frederick A., 54 Duncan av., Jersey City (9)
 Finn, Henry R. W., 84 Lembeck av., Jersey City (9)
 Finnerty, Urban R., 71 Park st., Montclair (7)
 Fiorello, Joseph R., 689 Princeton av., Trenton (11)
 Fischer, David D., 356 Millburn av., Millburn (7)
 Fischman, Harold H., 326 Avon av., Newark (7)
 Fish, Clyde M., 7 W. Washington av., Pl's'ntv'le(1)
 Fisher, James A., 501 Grand av., Asbury Park (13)
 Fisher, Samuel, 808 Madison av., Paterson (16)
 Fishkoff, Alexander H., 132Market st.,P'thAmb'y(12)
 Fisler, Charles F., 140 Maple st., Clayton (8)
 Fissell, George M., 530 Orange st., Newark (7)
 Fitch, Thomas S. P., 916 Park av., Plainfield (20)
 Fithian, George W., 266 High st., Perth Amboy (12)
 Fitzhugh, Wm. F., 190 Euclid av., Ridgefield P'k (2)
 Fitzpatrick, Edw. F., 546 W. Market st., Newark (7)
 Fitzpatrick, Leo J., 134 Bergen av., Ridgefield P'k(2)
 Flanagan, John J., 173 Roseville av., Newark (7)
 Fleischmann, Viola G., 341 16th av., Irvington (7)
 Fleming, Chas. L., 42 W. Main st., Pennsgrove (17)
 Fleming, Joseph A., 247 Claremont av., Montclair(7)
 Flichtenfeld, Morris, 283 4th st., Jersey City (9)
 Flicker, David J., 342 Kearny av., Kearny (9)
 Fliegel, Wm. M., 85 W. Passaic st., Maywood (2)
 Flint, Edgar T., 44 E. Somerset st., Raritan (18)
 Fliteroft, William, 510 River st., Paterson (16)
 Flower, Morrie A., 39 Lincoln Park, Newark (7)
 Fluck, David A., 626 W. State st., Trenton (11)
 Fluck, Paul H., 73 North Union st., Lambertville(10)
 Flynn, Edward A., 161 Washington av., Belleville(7)
 Flynn, Thomas H., 41 W. High st., Somerville (18)
 Foley, James F., 331 N. Grove st., East Orange (7)
 Fooder, Horace M., 110 Main st., Williamstown (8)
 Forbes, John S., Jr., Cedar st., Basking Ridge (14)
 Ford, Theodore R., 144 Harrison st., E. Orange (7)
 Forer, Robert, 247 Centre st., Trenton (11)
 Forney, Norman N., 96 N. Main st., Milltown (12)
 Forney, Norman N., Jr., 114 VanLieu av.,Milt'n(12)
 Forsyth, Kenneth C.,130MacLaren st.,Ott'wa,Can.(7)
 Fort, J. Irving, 306 Roseville av., Newark (7)
 Fort, Wm. B., 147 E. 7th st., Plainfield (20)
 Forte, Daniel L., 545 Central av., Orange (7)
 Forte, F. Chester, 111 State st., Hackensack (2)
 Forte, Frank S., 318 Roseville av., Newark (7)
 Fortunato, Samuel J., 345 Walnut st., Newark (7)
 Post, William H., 107 Franklin st., Belleville (7)
 Foster, Frank L., 320 Springfield av., Cranford (20)
 Foster, Herbert W., 2 Erwin Park, Montclair (7)
 Foster, Wm. S., 233 Mt. Prospect av., Newark (7)
 Fourcher, Kenneth R., Standard Oil Co., Linden (20)
 Fowler, Royale H., 744 Broad st., Newark (7)
 Fox, Wm. W., 101 S. Indiana av., Atlantic City (1)
 Frank, Morris, 920 Ave. C, Bayonne (9)
 Frank, Myrtile, 227 Philadelphia av., Egg Harbor(1)
 Frank, Nathan, 186 Bowers st., Jersey City (9)
 Frank, Reuben, Hanover&H'mpt'n sts.,Pembert'n(3)
 Franklin, Frank A., 304 Central av., Orange (7)
 Franklin, I. Harold, 191 Palisade av., Jersey City(9)
 Franklin, Jos. E., 127 Westfield av., Elizabeth (20)
 Franklin, Lewis J., 149 Jean ter., Union (20)
 Franzoni, Andrew E., 938 Brunswick av.,Trenton(11)
 Freedman, Harold H., 63 W. Main st., Freehold (13)
 Freedman, Jacob S., 178 Hamilton av., Passaic (16)
 Freeland, Frank, 281 State st., Hackensack (2)
 Freeman, George C., Prudential Ins. Co., Newark(7)
 Freeman, Joseph, 146 W. 32nd st., Bayonne (9)
 Freinkel, Jacob, 2 Hillside av., Newark (7)
 Freyberger, George A., 29 48th st., Weehawken (9)
 Fridrich, Harry E., 4172 Federal st., Camden (4)
 Friedenber, Sidney, 2990 Alabama rd., Camden (4)
 Friedland, Arnold J., Woodbine (5)
 Friedman, Abraham I., 280 State st., Hackensack(2)
 Friedman, Harry, 721 S. 16th st., Newark (7)
 Friedman, Hyman, 1096 Sanford av., Irvington (7)
 Friedman, Max, 493 Chambers st., Trenton (11)
 Friedman, Meyer H., 526 N. Clinton av., Trenton(11)
 Friedman, Milton, 31 Lincoln Park, Newark (7)
 Friedmann, Leonard L.,484Princeton av.,Trent'n(11)
 Frieman, Hyman, 744 Ave. C, Bayonne (9)
 Fritts, Lewis C., West End av., Somerville (18)
 Fritz, John F., Jr., 95 Main st., Flemington (10)
 Froelich, Joseph C., 74 Ingraham pl., Newark (7)
 Frohwein, Ida H., 125 Morristown rd., Elizabeth(20)
 Frost, Inglis F., 181 South st., Morristown (14)
 Frundt, Oscar C., 92 Bartholdi av., Jersey City (9)
 Frutig, Harold C., 508 36th st., N. Bergen (9)
 Fuchs, Jacob N., 1267 S. Broad st., Trenton (11)
 Fuhrmann, Barclay S., 10 Main st., Flemington (10)
 Furman, Benj. A., 31 Roseville av., Newark (7)
 Furman, Sol T., 349 Fairmount av., Jersey City (9)
 Furst, Nathan J., 299 Clinton av., Newark (7)

ASSOCIATE MEMBERS

- Feinsod, Samuel N., 1305 Clinton av., Irvington (7)
 Fischbein, Martin M., 817Chancellor av.,Irvington(7)
 Forman, Douglas N., N. J. State Hosp., Trenton (11)
 Fortuin, Floyd, 423 Broadway, Paterson (16)
 Frame, Dorothy L., 395 Franklin st., Bloomfield (7)
 Friedenthal, Bernard, 88Liv'gst'n av.,N'wBrnwk.(12)

G

ACTIVE MEMBERS

- Gadomski, Casimir F., 331 S. Broad st., Elizab'h(20)
 Gairdner, Thos. M., 319 W. Broad st., Gibbstown (8)
 Galgoczy, Julius, Manville (18)
 Galieto, Frank M., 188 Ampere Pkwy., Bloomf'd(7)
 Gallardo, Agustin, 61 Lakeside av., Pmptn. Lks.(16)
 Gallaway, George E., 163 W. Milton av., Rahway(20)
 Gallo, James S., 594 Broadway, Paterson (16)
 Gamba, Joseph, 345 Fairmount av., Newark (7)
 Gambill, Perry J., N. J. State Hosp., Gr'y'st'neP'k(14)
 Gamon, Robert S., 527 Cooper st., Camden (4)
 Ganley, Arthur J., 390 Park av., East Orange (7)
 Gannon, Joseph M., 1137 Park av., Plainfield (20)
 Ganot, Frank I., 392 Ridge st., Newark (7)
 Gardam, Joseph W., 16 Longfellow av., Newark (7)
 Gardner, Kenneth E., 45 Fremont st., Bloomfield (7)
 Garibaldi, Louis J., 1016 Hudson st., Hoboken (9)
 Garrison, W. Sherman, Main st., Cedarville (6)
 Garwood, Norman W., Main st., Crosswicks (11)
 Gauch, William, 177 Ellwood av., Newark (7)
 Gaumer, George W., 422 First st., Lakewood (15)
 Gauzza, Valentine P., 505 New Br'ns'w'k av., Fords(12)
 Geary, Daniel J., 40 Maple av., Morristown (14)
 Geary, Paul, 909 Park av., Plainfield (20)
 Geary, Russell D., 337 Bridgeboro rd., Riverside (3)
 Geiger, Harold C., Main st., West Milford (16)
 Geissler, Elmer E., 327 Monmouth st., Gloucester(4)
 Gelber, Isaac, 2052 Morris av., Union (20)
 Geller, Samuel, 784 High st., Newark (7)
 Gelman, Sidney, 579 Broadway, Paterson (16)
 Gencher, Benjamin, 24 Ravine av., Caldwell (7)
 Gennell, Ernest, 298 Parker st., Newark (7)
 George, Melbourne E. W., 744 Broad st., Newark (7)
 Gerard, Patrick D., 364 Roseville av., Newark (7)
 Gerendasy, Julius, 956 E. Jersey st., Elizabeth (20)
 Germain, Raymond J., High Bridge (10)
 German, George B., 429 Cooper st., Camden (4)
 Gerner, Harry E., 2787 Blvd., Jersey City (9)
 Gershenfeld, David B., 20 Hillside av., Newark (7)
 Gershman, Joseph G., 185 E. Madison av., Dumont(2)
 Gessner, Gerard R., 28 S. 3rd av., Highland Park(12)
 Gesswein, Carl A., 35 Church st., Matawan (13)
 Ghee, Euclid P., 115 Claremont av., Jersey City (9)
 Giacalone, Vincent, 649 Landis av., Vineland (6)
 Giambra, Sante M., 666 Broadway, Paterson (16)
 Giannetti, Ernest D., 14 Harrison av., Montclair (7)
 Gibb, Alice S., 339 Union av., Elizabeth (20)
 Gibb, W. Blake, 26 Maple av., Morristown (14)
 Gibbins, Albert L., 119 5th st., Newark (7)
 Gibson, Augustus, 635 Valley rd., Up. Montclair (7)
 Giffoniello, Arthur A., 200 Fairmount av., Newark(7)
 Gifford, Wm. R., 247 Park av., East Orange (7)
 Giglio, Alphonsus S. V., 626 Elizabeth av., Elizab'h(20)
 Gilady, Raphael, 205 Union st., Hackensack (2)
 Gilbert, Philip D., Cooper Hospital, Camden (4)
 Gilbertson, Robert L., 55 Maple av., Morristown (14)
 Gilligan, Walter W., 16 Enclosure st., Nutley (7)
 Gillis, Alfred G., 19 Maple st., Clayton (8)
 Gillson, Hugh V., 21 Lee pl., Paterson (16)
 *Gillson, John T., 170 Broadway, Paterson (16)
 Gilman, Charles M. B., 59 Seeley av., Arlington (7)
 Gilpin, Fletcher, 118 North av. W., Cranford (20)
 Gilson, John A., Jr., 220 8th av., Haddon Heights (4)
 Gindhart, John H., 1233 Hamilton av., Trenton (11)
 Ginsberg, George, 624 Bloomfield st., Hoboken (9)
 Ginsberg, Leon, Essex Co. Hosp., Cedar Grove (7)
 Ginsburg, Samuel, 27 Paulison av., Passaic (16)
 Girardo, Anthony J., 22 Taunton av., Berlin (4)
 Gittelman, Morton, 426 Westminst'r av., Elizab'h(20)
 Gittelsohn, Isador, 896 Kind'rk'm'k rd., RiverEdge(2)
 Giuffra, Frank, 161 Park st., Montclair (7)
 Gladstone, Albert L., 404 Hickory av., Paramus (2)
 Gladstone, Sidney A., Barnert Mem. Hosp., Pat'r's'n(16)
 Glaser, Emanuel, 360 Linden av., Elizabeth (20)
 Glasgow, Thomas M., 120 Passaic av., Passaic (16)
 Glass, Benjamin E., 609 Watchung av., Plainf'd(20)
 Glass, Oscar, 838 S. 12th st., Newark (7)
 Glass, Wm. H., 144 Harrison st., East Orange (7)
 Glasser, Benjamin F., 316 George st., NewBrun.(12)
 Glassner, Frank, 308 Chestnut st., Roselle (20)
 Glasston, Hyman M., 628 N. Wood av., Linden (20)
 Glazebrook, Francis H., "H'neys'ckle W'ds", R'm's'n(14)
 Glazer, Edward, 501 Grand av., Asbury Park (13)
 Glazier, Jesse T., 670 Sanford av., Newark (7)
 Gleeson, William J., 640 Bergen av., Jersey City (9)
 Glover, Lawrence L., 53 King's Hwy., W., Had'nf'd(4)
 Gluckman, Saul K., 78 Johnson av., Newark (7)
 Gnassi, Angelo M., 130 Wegman Pkwy., Jer. C'y(9)
 Gochman, Harry M., 166 Hamilton av., Paterson(16)
 Godfrey, Alan O., 231 Roseville av., Newark (7)
 Goeller, Jacob D., 1165 W. Clinton av., Irvington(7)
 Goff, Frank J., 64 Maple av., Red Bank (13)
 Goffman, Emanuel, 316 Claremont av., Montclair(7)
 Goldberg, Benjamin M., 1156 E. State st., Trenton(11)
 Goldberg, David, 7 Bogert pl., Westwood (2)
 Goldberg, Harold H., 814 S. 10th st., Newark (7)
 Goldberg, Harry C., 135 Market st., Perth Amboy(12)
 Goldberg, Isidore, 303 N. Wash'gton av., Dunellen(12)
 Goldberg, Louis E., 31 Lincoln Park, Newark (7)
 Goldberg, Samuel A., 169 Gregory av., W. Orange(7)
 Goldberg, Samuel M., 353 Washington av., Bellv'le(7)
 Golden, Clement H., 347 16th av., Irvington (7)
 Golden, Wm. M., 236 W. Milton av., Rahway (20)
 Goldenberg, Raphael R., 588 E. 27th st., Paterson(16)
 Goldfarb, Abraham, 52 Chestnut st., Rutherford (2)
 Goldfield, Harold H., 225 E. Jersey st., Elizabeth(20)
 Golding, Harry N., 180 Carroll st., Paterson (16)
 Goldmacher, Herman B., 113 Elmora av., Elizab'h(20)
 Goldman, Leo L., 325 Market st., Trenton (11)
 Goldman, Lester M., 896 S. 16th st., Newark (7)
 Goldman, Samuel, 7th & State sts., Camden (4)
 Goldman, Solomon, 77 Liv'gston av., N'w Br'ns'w'k(12)
 Goldowsky, Ira, 23 Warner av., Jersey City (9)
 Goldstein, Abraham, 404 Madison av., Lakewood (15)
 Goldstein, Henry Z., 31 Lincoln Park, Newark (7)
 Goldstein, Herman H., 318 W. Jersey st., Elizab'h(20)
 Goldstein, Hyman I., 1425 Broadway, Camden (4)
 Goldstein, Samuel, 16 E. Main st., Mays Landing(1)
 Goldstein, Wm. H., 632 Belgrove dr., Arlington (7)
 Goldstone, Karl H., 16 18th st., West New York (9)
 Gonczy, Edward J., 538 Jersey av., Elizabeth (20)
 Goodfellow, Gordon P., 196 Prosp't st., E. Orange(7)
 Goodrich, Stewart L., 812 Ave. C, Bayonne (9)
 Gordon, Abel, 616 Main av., Passaic (16)
 Gordon, Benjamin L., 1616 Pacific av., Atlantic C'y(1)
 Gordon, Charles D., Mt. Arlington (14)
 Gordon, Isaac L., 1815 Hudson Blvd., Jersey City (9)
 Gordon, J. Berkeley, N. J. State Hosp., Marlboro(13)
 Gordon, Milton H., 12 N. 27th st., Camden (4)
 Gordon, Samuel, 515 Broadway, Paterson (16)
 Gorenberg, Harold, 126 Gifford av., Jersey City (9)
 Gormley, Cyrus M., 15 Kiel av., Butler (16)
 Gottlieb, Morris, 1616 Pacific av., Atlantic City (1)
 Gould, John H., 123 Prospect st., Ridgewood (16)
 Gould, Werner, 219 Passaic st., Hackensack (2)
 Graddick, Lester W., 22 Sussex av., Morristown (14)
 Grady, Wm. F., 42 N. Fullerton av., Montclair (7)
 Graeter, F. Albert, 265 Gregory av., Passaic (16)
 Graham, Archibald F., 42 Park av., Paterson (16)
 Graham, Ernest E., 4273 S. Broad st., Yardville (11)
 Graham, Richard B., 575 Belgrove dr., Arlington (7)
 Graham, Theodore K., 279 Park av., Paterson (16)
 Gramsch, A. Louis, Bergen Pines, Oradell (2)

- Granberry, D. Webb, 136 S. Main st., Orange (7)
 Granelli, Humbert A., 213 Garden st., Hoboken (9)
 Grant, Wm. E., 1370 Morris av., Union (20)
 Grant, Wm. F., 309 Roseville av., Newark (7)
 Graves, Chas. C., Jr., N. J. State Hosp., Marlboro(13)
 Gray, Chas. M., 6th and Grape sts., Vineland (6)
 Gray, John W., 142 Clinton av., Newark (7)
 Gray, W. Burritt, 121 Somerset st., N. Plainfield (18)
 Green, David W., 69 Market st., Salem (17)
 Green, Morris, 234 48th st., Union City (9)
 Green, Thomas J., New Egypt (15)
 Greenberg, Geo. A., 195 W. High st., Somerville (18)
 Greenberg, Max, 29 W. Henry st., Linden (20)
 Greenberg, Philip, 1902 Hudson Blvd., Jersey City(9)
 Greenberg, Samuel, 46 Johnson av., Newark (7)
 Greenberg, Solomon, 52 Ave. B, Bayonne (9)
 Greene, Albert D., 195 Palisade av., Union City (9)
 Greene, Harry, 3285 Hudson Blvd., Jersey City (9)
 Greenfield, Arthur W., 50 Anderson st.,H'ck'ns'k(2)
 Greenfield, Bernard H., 691 Clinton av., Newark (7)
 Greenfield, Leonard S., 691 Clniton av., Newark (7)
 Greenfield, Wm. J., 50 Anderson st., Hackensack (2)
 Greengrass, Jacob J., 146 Broadway, Paterson (16)
 Greenwald, Theo. L., 44 Maple av., Morristown (7)
 Greenwood, Wm. R., 118 Somerset st.,NewBruns.(12)
 Greer, Melvin A., 190 Washington st., Bloomfield(7)
 Gregorius, Ralph F., 120 Irvington av., S. Orange(7)
 Gregory, Marie F., 50 Green Village rd.,Madison(14)
 Gregory, Mildred G., 64 N. 9th st., Newark (7)
 Gregory, Roy A., 726 Watchung av., Plainfield (20)
 Greifinger, Marcus H., 200 Ferry st., Newark (7)
 Grenhart, Geo. W., 430 Haddon av., Camden (4)
 Grieco, Emil H., 196 Broadway, Bayonne (9)
 Grier, Robt. M., 50 E. Wash'gt'n av.,Pl'santville(1)
- Griesemer, Z. Lawrence, 1145 E. Jersey st.,Eliz.(20)
 Grieve, James, 88 Market st., Perth Amboy (12)
 Griffey, Wm. C., 132 Haddon av., Westmont (4)
 Griffin, Guy B., 197 S. Centre st., Orange (7)
 Griffith, Roy, 909 Broad st., Newark (7)
 Grimes, Jesse R., 214 Washington av., Dumont (2)
 Grimes, Robert R., 455 Queen Anne rd., Teaneck (2)
 Griscom, I. Norwood, 204 Church st., Boonton (14)
 Griscom, Lee E., 604 Broadway, Camden (4)
 Griswold, Merton L., Jr., 947 Park av., Plainfield(20)
 Groeschel, August H., 31 Bank st., Sussex (19)
 Groff, Parker A., 159 Washington av., LittleFerry(2)
 Gross, Isidore, 60 Lakeside av., Verona (7)
 Gross, Max, 109 States av., Atlantic City (1)
 Grossblatt, Philip, 67 Baldwin av., Newark (7)
 Grossman, Morris, 921 Bergen av., Jersey City (9)
 Grossman, Rubin, 377 Ave. C. Bayonne (9)
 Grubin, Harold, 22 Treacy av., Newark (7)
 Grueninger, Edw. F., 24 Columbia av.,CliffsideP'k(2)
 Grunt, Louis, 35 Shanley av., Newark (7)
 Guertin, Diomede, N. J. State Village, Skillman (18)
 Guglielmelli, Angelo D., 449Hamilton av.,Trent'n(11)
 Guidi, Guido M., 212 Christine st., Elizabeth (20)
 Guidotti, Frank P., 703 Hamilton av., Trenton (11)
 Guillion, Wm. H., 505 Fourth av., Asbury Park (13)
 Guion, Edward, Shore rd., Northfield (1)
 Gulick, James B., 144 S. Harrison st., E. Orange (7)
 Gullford, Edward G., 284 Bellevue av., Up.Montcl'r(7)
 Gurnee, Quinby D., 168Diam'ndBr.av.,Hawth'rne(16)
 Gurshman, Sol., 280 Amboy av., Metuchen (12)
 Guthrie, Wilson G., 300 Summer av., Newark (7)
 Gutmann, Erwin K., 229 Bowers st., Jersey City (9)
 Gutowski, Jos. M., 433 Brace av., Perth Amboy (12)
 Gutowski, Walter T., 104 Grove ter., Irvington (7)

ASSOCIATE MEMBERS

- Gadek, Stanley A., 95 Fayette st., Perth Amboy (12)
 Garber, Robert S., N. J. State Hosp., Trenton (11)
 Gereben, Arpad G., 511 Rahway av., Woodbridge(12)
 Greenberg, Mortimer, 1463 Maple av., Hillside (7)

H

ACTIVE MEMBERS

- Hackett, Edward J., 597 Westfield av., Westfield(20)
 Hackett, Leon W., 173 Belvidere av.,Washington(21)
 Hadley, C. Frazer, 210 W. Maple av., Merch'tville(4)
 Hadley, C. Frazer, Jr., 21 Haddon av.,Westmont(4)
 Hadley, Elinor E., 5 Mountain av., Maplewood (7)
 Hafetz, M. Morris, 114 Centre st., Trenton (11)
 Hagen, Orville R., 266 Van Houten st., Paterson(16)
 Hagen, Walter H., 85 Harrison st., East Orange (7)
 Haggerty, D. Leo, 227 N. Warren st., Trenton (11)
 Hagman, Frank E., 131 Ridge rd., N. Arlington (7)
 Hahn, Katherine B., 372 Thornden st.,So.Orange(7)
 Hahn, William H., 15 Lombardy st., Newark (7)
 Haight, Harry W., 118 Raritan av., HighlandP'k(12)
 Haines, Edgar J., Medford (3)
 Haines, Emerson S., 500 8th av., Asbury Park (13)
 Haines, Evelyn M., 1022 Greenw'd av., Trenton (11)
 Haines, Mabel C. S., 600 White HorsePk.,Audubon(4)
 Haines, Willits P., 601 9th st., Ocean City (5)
 Halbstein, Bernard M., 138 Bath av.,LongBranch(13)
 Haldeman, Robert E., Mt. Holly (3)
 Haley, Paul W., 781 Sanford av., Newark (7)
 Hall, Perry O., 2553 Hudson Blvd., Jersey City (9)
 Hall, Wayne W., 266 Van Houten st., Paterson (16)
 Hall, Winthrop H., 400 Elm st., Westfield (20)
 Hallett, Frederick S., 200 Passaic st.,Hackensack(2)
- Halligan, Earl J., 254 Montgomery st., JerseyC'y(9)
 Halligan, Harold J., 254Montgomery st.,JerseyC'y(9)
 Hallinger, Earl S., 517 Cooper st., Camden (4)
 Hallock, Wilton J., 650 Springfield av., Summit (20)
 Halnan, John J., Jr., 631 Madison av., Paterson (16)
 Halperin, David, 590 Bergen av., Jersey City (9)
 Halpern, Herman, 143 Engle st., Englewood (2)
 Halpern, Jesse O., 135 E. Madison st., Dumont (2)
 Halpern, Melvin M., 493 Central av., Newark (7)
 Halpern, Samuel, 504 Pacific av., Atlantic City (1)
 Halpern, Sophia L., 1311 Palisade av., Union City (9)
 Halprin, Harry, 8 Washburn pl., Caldwell (7)
 Halsey, Levi W., 61 Church st., Montclair (7)
 Hamblin, Donald O., Calco Chem. Co.,BoundBr'k(18)
 Hambright, Arthur M., Wyckoff av., Ramsey (16)
 Hamilton, Lloyd A., 46 York st., Lambertville (10)
 Hamilton, Robert G., 92 Main st., Orange (7)
 Hammell, Frank M., 137 S. Main st., Allentown (11)
 Hampton, Geo. R., N. J. StateHosp.,Gr'y'st'neP'k(14)
 Hanan, James T., 11 The Crescent, Montclair (7)
 Hancock, Michael Q., 705 D st., Belmar (13)
 Handler, Harry, 305 York st., Jersey City (9)
 Haney, John J., 850 Hamilton av., Trenton (11)
 Hanrahan, James M., 678 N. Broad st., Elizabeth(20)
 Hansen, Harry, 916 Park av., Plainfield (20)

- Hanson, Alfred S., 533 Monmouth st., Gloucester(4)
Hanson, Carl G., 38 Springfield av., Cranford (20)
Hantman, Harold, 196 Roseville av., Newark (7)
Harden, Albert S., 510 W. Market st., Newark (7)
Harden, Albert S., Jr., 551 Ridgew'd rd., Maplew'd(7)
Hardy, John W., 53 Main st., Farmingdale (13)
Harley, Halvor L., 101 S. Indiana av., Atlantic C'y(1)
Harman, Byron M., Essex Mt. Sana., Verona (7)
Harman, James R., 824 W. State st., Trenton (11)
Harman, William J., 740 W. State st., Trenton (11)
Harreys, Chas. W., 153 Prospect st., Ridgewood(16)
Harrington, J. Henry, 126 E. Main st., Rockaway(14)
Harris, Morris, 1 Park pl., Bloomfield (7)
Harris, William G., Main st., Mullica Hill (8)
Harrop, George A., 33 Cleveland lane, Princeton (11)
Harryman, Wm. K., 271 Union st., Hackensack (2)
Harter, Louis F., 174 Bowers st., Jersey City (9)
Hartman, Luther M., 111 E. Main st., Maple Shade(3)
Hartman, Winfield, Jr., 2 Elm court, So. Orange (7)
Hartwell, H. Ameroy, 777 Blvd. East, Weehawken(9)
Harvey, John W., 818 Ave. C, Bayonne (9)
Harvey, Robt. K., 711 Kearny av., Arlington (7)
Harvey, Thomas W., Jr., 59 Main st., Orange (7)
Haseltine, Sherwin L., 125 Broad st., Elizabeth (20)
Hasking, Arthur P., 318 Montgomery st., Jer.City(9)
Hatch, Harold S., Shonghum Mt.Sana., Morrist'n(14)
Hatcher, George A., Essex Co. Hosp., Cedar Grove(7)
Hatem, Elias J., 1046 Main st., Paterson (16)
Hauber, Eugene A., 6 Quaid st., Sayreville (12)
Hauck, Lydia R. B., 644 Stuyvesant av., Irvington(7)
Hauck, Wm. H., 644 Stuyvesant av., Irvington (7)
Hauptman, Harry, 88 Sherman pl., Jersey City (9)
Haury, Victor G., 206 Cedarcroft av., Audubon (4)
Hausman, Samuel W., 50 W. Front st., Red B'nk(13)
Haussling, Francis R., 661 High st., Newark (7)
Haven, Samuel C., 14 Elm st., Morristown (14)
Hawes, Vernon L., 63 Church st., Ramsey (2)
Hawke, Edward K., 113 Main st., Newton (19)
Hawkes, E. Zeh, 84 Washington st., Newark (7)
Hawkes, Stuart Z., 84 Washington st., Newark (7)
Hayes, Gerald W., 86 Hawthorne av., E. Orange (7)
Hays, Roy G., 567 Haddon av., Collingswood (4)
Haywood, Henry, 49 Paterson st., NewBrunsw'k(12)
Heasley, Wm., 23 Monmouth st., Red Bank (13)
Heaton, Stuart C., Calco Chem. Co., Bound Br'k(18)
Hegeman, Runkle F., 161 W. High st., Som'rville(18)
Heineken, Theodore S., 17 Park pl., Bloomfield (7)
Hekimian, Jacob H., 2314 Palisade av., Union City(9)
Helff, Joseph R., 1367 Teaneck rd., W. Englew'd (2)
Heller, Abraham R., 10 Kearny av., Kearny (7)
Heller, George, 460 Engle st., Englewood (2)
Heller, Nathan B., 31 Lincoln Park, Newark (7)
Hemphill, Everett H., 232 Kings Hwy., E., H'd'nf'd(4)
Henderson, Kenneth P., Ansley Park, Pl's'ntville(1)
Henle, Carye-Belle, 671 Springfield av., Newark (7)
Hennig, Paul F., 688 Stuyvesant av., Irvington (7)
Henriksen, J. Bruce, 422 River av., P't Pl'sant (15)
Henry, Frank C., Jr., 220 Smith st., Perth Amboy(12)
Henry, George, 33 Mine st., Flemington (10)
Hensle, Otto S., 5 Pangborn pl., Hackensack (2)
Herbener, Eugene G., 423 Third st., Lakewood (15)
Hermann, John H., 197 S. Centre st., Orange (7)
Herndon, Lewis S., 144 S. Harrison st., E.Orange(7)
Herold, Harvey T., 850 S. 13th st., Newark (7)
Herradora, Juan R., 2787 Blvd., Jersey City (9)
Herrington, Lee R., 605 E. Broad st., Westfield (20)
Herrman, Wm. G., 501 Grand av., Asbury Park (13)
Hersh, David H., 658 Springfield av., Newark (7)
Hersohn, Wm. W., 116 S. Illinois av., Atlantic C'y(1)
Hess, George A., River rd., Titusville (11)
Hesseltine, Clair E., 269 Borden'tn av., So. Amboy(12)
Hessert, Edmund C., 417 Cooper st., Camden (4)
Hewson, George F., 21 Roseville av., Newark (7)
Hexamer, Fred, 50 Lyons av., Newark (7)
Heyman, Arthur, 79 Baldwin av., Newark (7)
Heyman, Ernest, 345 Broad st., Red Bank (13)
Hiden, Joseph C., 199 Nassau st., Princeton (11)
Higgins, Gerald L., 125 Lembeck av., Jersey City(9)
Higgins, John T., 145 Highland av., Jersey City (9)
Higgins, Thos. A., 2616 Hudson Blvd., Jersey C'y(9)
Higi, Joseph E., 31 Lincoln Park, Newark (7)
Hiler, Stuart A., 62 Rockaway av., Rockaway (14)
Hilker, George F., 258 Maple st., Perth Amboy (12)
Hill, Clarence T., 116 E. Hazelwood av., Rahway(20)
Hill, James O., 84 Barclay st., Newark (7)
Hill, John A., 511 Cedar av., Allenhurst (13)
Hill, Robert H., 339 Parker st., Newark (7)
Hill, William F., 104 Grand st., Jersey City (9)
Hillel, Joseph, 464 Woodcliff av., Hudson Heights(9)
Hillard, William T., 105 Market st., Salem (17)
Hillmann, Frederick C., 64 Hamilton st., Paterson(16)
Hillsman, Robert B., 268 Vandelinda av., Teaneck(2)
Hindle, F. Lawton, 145 Maple av., Red Bank (13)
Hinton, Samuel H., 123 Main st., Sayreville (12)
Hipple, Percy L., 230 Walnut st., Roselle (20)
Hird, Emerson F., 118 E. Maple av., Bound Br'k(18)
Hirschberg, Samuel, 615 High st., Newark (7)
Hirschfield, Bernard A., 438 Hamilton av., Trenton(11)
Hirst, E. Reed, 634 Federal st., Camden (4)
Hitzemann, Louis A., 30 E. Passaic st., Maywood(2)
Hnat, Frederick, 624 Newark av., Elizabeth (20)
Hobart, Richard T., 454 Park st., Upper Montcl'r(7)
Hochheimer, Arthur, 211 Hamilton st., Bound Br'k(18)
Hodas, Sidney M., 158 Maple av., Red Bank (13)
Hofer, Clarence J. M., 463 Main st., Metuchen (12)
Hoffman, Charles A., 302 E. 7th st., Plainfield (20)
Hoffman, Charles W., 261 Henry st., So. Amboy(12)
Hoffman, Florentine M., 91 Bayard st., N'w Brns.(12)
Hoffman, Harry S., 3302 Pacific av., Atlantic City(1)
Hogan, Carlton P., 220 E. Union st., Burlington (3)
Hogan, James J., New Egypt (15)
Hogan, Marshall D., 311 W. Main st., Boonton (14)
Holland, Moses H., 2412 Palisade av., Weehawken(9)
Holland, Reuben J., 1026 Chandler av., Linden (20)
Holler, Henry G., 234 Montclair av., Newark (7)
Hollingshead, Lyman B., Pemberton (3)
Hollingsworth, H. Hale, 86 First st., Clifton (16)
Hollinshed, Beulah S., 600 Benson st., Camden (4)
Hollinshed, Ralph K., 351 Broadway, Westville (8)
Hollywood, Jas. L., 219 Danforth av., Jersey City(9)
Holman, Francis W., 123 Broad st., Keyport (13)
Holmes, George J., 17 Elizabeth av., Newark (7)
Holmes, Grace A., 1077 E. Jersey st., Elizabeth (20)
Holmes, H. David, 1813 Arctic av., Atlantic City (1)
Holmes, Thos. J. E., 151 Fair st., Paterson (16)
Holoman, M. Browne, 1 N. Haverford av., Margate(1)
Holster, Stephen G., 951 Madison av., Paterson (16)
Holt, Edward Z., 4100 Atlantic av., Atlantic City(1)
Holt, Evelyn, 261 Springfield av., Summit (20)
Holt, Herman H., 256 Graham av., Paterson (16)
Holters, Otto R., 1002 Emory st., Asbury Park (13)
Holtz, Harry M., 56 Johnson av., Newark (7)
Hoops, Harold J., 2203 Boulevard, Jersey City (9)
Hooton, Thomas C., 31 Trinity pl., Montclair (7)
Horhevit, George I., 324 S. Broad st., Trenton (11)
Horn, Harry, 622 Stuyvesant av., Irvington (7)
Horn, Max, 850 So. 11th st., Newark (7)
Hornberger, J. Howard, 4th & Main sts., Roeb'ing(3)
Hornstine, Harry H., 4015 Pacific av., Wildwood (5)
Horoschak, Anne, 974 Park av., Plainfield (20)
Horowitz, Herman J., 872 Broad av., Ridgefield (2)
Horre, George W. H., 203 W. Jersey st., Elizab'h(20)
Horsford, Frederick C., 305 Broadway, Newark (7)
Hosp, Paul H., 842 S. 12th st., Newark (7)
Houck, Wm. J., 207 Mt. Prospect av., Newark (7)
Howard, J. Edgar, 67 King's Hky., W., Had'nf'd(4)
Howard, Jas. W., 87 Midland av., Montclair (7)
Howeth, John L., 14 Duncan av., Jersey City (9)
Hubbard, Fayette E., 65 Church st., Montclair (7)
Hubbard, Harry H. V., 121 E. 7th st., Plainfield (20)

- Hubbard, Robert Y., 942 Sanford av., Irvington (7)
Huber, Wm. H., 587 Prospect st., Maplewood (7)
Huberman, John, 853 S. 12th st., Newark (7)
Hubert, Antonio O., 131 E. Main st., Rockaway (14)
Hudson, W. Johnson, 39 E. W'sh'gt'n av., Pl'tntv'le(1)
Huff, Edmund N., 1635Bedford rd.,SanMarino,Cal.(2)
Hughes, Frank R., Col'mbia av.&Oc'n st.,CapeM'y(5)
Hughes, Frederic J., 706 Park av., Plainfield (20)
Hughes, J. Vernon, 655 Main av., Passaic (16)
Hughes, Joseph F., 116 N. Broad st., Woodbury (8)
Hughes, Lee W., 965 Broad st., Newark (7)
Hughes, Sam'l B., Pine & Pacific avs., Wildwood(5)
Hughes, Thomas E., 223 Cooper st., Camden (4)
Hulett, Albert G., 20 Hawthorne av., E. Orange (7)
Hull, Donald B., 88 W. Ridgewood av.,Ridgewood(2)
Humbert, Joseph C., Jr., Stewartsville (1)
Hummel, Ernest G., 414 Cooper st., Camden (4)
Hummel, Lec C., 109 W. Broadway, Salem (17)
Hummel, Merwin L., 135N.Centre st.,Merch'ntv'le(4)
Humphrey, Hubert G., 430 Downer st., Westfield (7)
Humphries, Robert E., 637 Central av.,E.Orange(7)
Hunt, Melvin M., 140 Jackson st., South River (12)
Hunt, Thomas F., 528 Monroe av., Elizabeth (20)
Hunter, Edward R., 321 Union av., Delanco (3)
Hunter, Floyd D.,3620Not'gh'm way,Hamilt'nSq.(11)
Hunter, Harold H., 114 W. Broad st., Paulsboro (8)
Hurff, J. Wallace, 86 Washington st., Newark (7)
Husserl, Siegfried, 777 Clinton av., Newark (7)
Husted, Gerald W., 306 8th av., Haddon Hgts. (4)
Husted, Saumel H., Neshanic Station (18)
Hutchinson, A. Dunbar, 913 W. State st.,Trenton(11)
Hutchinson, Geo. F., 55 Mercer st., Hamilton Sq.(11)
Hutner, Cyril L., 134 Grove st., Woodbridge (12)
Hutton, Frederick T., 915 Park av., Plainfield (20)
Hyman, Charles, 2619 Pacific av., Atlantic City (1)
Hymowitz, Ben, 66 Baldwin av., Newark (7)

ASSOCIATE MEMBERS

- Haschec, Walter, 690 S. 19th st., Newark (7)
Hayman, Irving R., 681 Broadway, Paterson (16)
Hirsch, Theodore, 842 So. 13th st., Newark (7)
Howley, Barth, Jr., 15 N. 6th av., New Brunsw'k(12)

I

ACTIVE MEMBERS

- Ianacone, John A., 310 Fifth av., Paterson (16)
Ill, Carl H., 188 Clinton av., Newark (7)
Ill, Edgar A., 1004 Broad st., Newark (7)
Ill, Edmund W., 188 Clinton av., Newark (7)
Ill, Edward J., 1004 Broad st., Newark (7)
Ill, Herbert M., 188 Clinton av., Newark (7)
Imbleau, Joseph E. L., 2106Morris av.,Unionville(20)
Imhoff, Robert E., 29 E. Main st., Moorestown (3)
Infield, Gerald L., 1401 Shore rd., Northfield (1)
Inge, Hutchins F., 205 S. Orange av., Newark (7)
Inge, Theodore R., 336 Halsted st., East Orange (7)
Ingling, Harry W., 51 W. Main st., Freehold (13)
Introcaso, Dominick A., 45 Crescent av., Jer. City(9)
Iraggi, James V., 158 Gregory av., Passaic (16)
Ironside, Paul A., 571 Benson st., Camden (4)
Irving, Henry C., 13 Warner av., Jersey City (9)
Irwin, James R., 330 Washington av., Belleville (7)
Irwin, John H., 51 Tenaflly rd., Englewood (2)
Isaac, Benoit C., 227 Main st., Orange (7)
Ishkhanian, Nouri I.,6032Palisade av.,W.N'wYork(9)
Israeloff, Howard H., 1038 Clinton av., Irvington (7)
Ives, Edwin I., 24 Stevens av., Little Falls (16)
Ivins, William C., 214 E. Hanover st., Trenton (11)
Ivory, Harry S., Richmond av., Pt. Pleasant (15)
Izenberg, David, 555 E. 29th st., Paterson (16)

J

ACTIVE MEMBERS

- Jablonski, John J., 100 Main st., Sayreville (12)
Jack, H. Wesley, 538 Cooper st., Camden (4)
Jacks, Oscar, 476 Mercer st., Jersey City (9)
Jackson, Albert F., 225 Hillside av., Nutley (7)
Jackson, Charles H., 1250 Park Blvd., Camden (4)
Jackson, Dominick P. D., 420 Front st.,Belvidere(21)
Jackson, George H., 2092 Morris av., Union (7)
Jacobitti, Edmund E., 491 Maywood av.,Maywood(2)
Jacobs, Alan L., 1243 Stuyvesant av., Union (20)
Jacobson, J. Joseph, 1616 Pacific av., AtlanticCity(1)
Jacobson, Murray B., 138 Market st., P'thAmboy(12)
Jaffe, Benjamin, 566 Bergen av., Jersey City (9)
Jaffe, Herman M., 2600 Blvd., Jersey City (9)
Jaffe, Hyman, 149 Broadway, Passaic (16)
Jaffin, Abraham E., 41 Emory st., Jersey City (9)
Jahn, Albert G., 657 Main av., Passaic (16)
James, Bart M., 31 Lincoln Park, Newark (7)
James, J. Thomas, 199 Nassau st., Princeton (11)
James, William L., 31 Lincoln Park, Newark (7)
Jamison, Wm. F., 501 Grand av., Asbury Park (13)
Jani, Frank F., 297 Lexington av., Passaic (16)
Janifer, Clarence S., 208 Parker st., Newark (7)
Janoff, Henry, 626 Perry st., Trenton (11)
Jaques, J. Eugenia, 74 Waverly st., Jersey City (9)
Jarecki, Max M., 527 Bangs av., Asbury Park (13)
Jarmulowsky, Harry, 181 E. 33rd st., Paterson (16)
Jaso, James V., 710 Varsity rd., So. Orange (7)
Jaspan, Samuel C., 820 Division st., Trenton (11)
Jedel, Meyer, 125 Fourth st., Newark (7)
Jehl, Joseph R., 305 Clifton av., Clifton (16)
Jenkins, Alvah R., 40 Armory st., Englewood (2)
Jenkins, Arthur M., 701 Harrison st., Frencht'n(10)
Jennings, Robert E., 143 Park st., East Orange (7)
Jensen, Grover H., 451 Bergen av., Jersey City (9)
Jentz, John H., 63 Sherman pl., Jersey City (9)
Jessurun, Samuel H., 613 High st., Newark (7)
Jirouch, Edwin A., 18 Ziegler Tract,Pennsgrove(17)
Joelson, Dora, 485 Park av., Paterson (16)
Joelson, Morris S., 577 Broadway, Paterson (16)
Joffe, Philip M., 556 E. 28th st., Paterson (16)
Joffe, Sidney H., 556 E. 28th st., Paterson (16)
Johnsen, Sigurd W., 149 Prospect st., Passaic (16)
Johnson, George F., Branchville (19)
Johnson, G. Leonard, 390 Booth av., Englewood (2)

- Johnson, Harold F., 734 Park av., Plainfield (20)
 Johnson, Herbert F., Cooper Hospital, Camden (4)
 Johnson, John F., 113 Abernethy dr., Trenton (11)
 Johnson, V. Earl, 101 S. Indiana av., Atlantic C'y (1)
 Johnston, Julian F., 21 Van Doren av., Chatham (14)
 Johnston, Rufus O., Parkside rd., Harrington P'k (2)
 Johnston, Sidney F., 365 Rochelle av., Rochelle P'k (2)
 Jonas, August, 117 Broad st., Bridgeton (6)
 Jones, Clement M., 438 Boulevard, Bayonne (9)
 Jones, Granville L., N. J. State Hosp., Marlboro (13)
 Jones, Herbert E., 47 Elm st., Elizabeth (20)
 Jones, J. Morgan, Valley rd., Oakland (9)
 Jones, John C., 805 Princeton av., Camden (4)
 Jones, Lewis H., 139 E. Grant av., Roselle Park (20)
 Jones, Rhys, 33 S. Fullerton av., Montclair (7)
 Jonitz, Robert, 153 S. Grove st., East Orange (7)
 Jordan, Alexander D., 238 E. Main st., Manasquan (13)
 Jordan, Joseph C., Box A, Manasquan (13)
 Jordan, Walter L., 145 Engle st., Englewood (2)
 Joseph, Benjamin M., 2771 Hudson Blvd., Jer. C'y (9)
 Joseph, Morris, 271 Lexington av., Passaic (16)
 Joy, Ernest H., 802 N. Main st., Toms River (15)
 Joyce, Leo H., 259 Madison st., Passaic (16)
 Judd, Wilbur M., N. J. State Hosp., Greystone P'k (14)
 Judge, John F., 33 Hazelwood av., Newark (7)
 Judson, G. Vernon, Jr., 316 9th av., Haddon Hgts. (4)
 Judy, Kenneth H., 786 Ave. C, Bayonne (9)
 Jukofsky, Isidore D., 32 Union pl., Ridgefield P'k (2)
 Justin, Arthur W., 41 Fulton st., Weehawken (9)

ASSOCIATE MEMBER

- Johnson, Robert A., 5 Bloomfield av., Belleville (7)

K

ACTIVE MEMBERS

- Kachdorian, Vartan, 930 Brunswick av., Trenton (11)
 Kaderabek, Erwin J., 144 S. Harrison st., E. Orange (7)
 Kahn, Leo, 32 States av., Atlantic City (1)
 Kahrs, Grace M., 140 Roseville av., Newark (7)
 Kaighn, Charles B., 905 Pacific av., Atlantic City (1)
 Kain, Thomas M., 403 Cooper st., Camden (4)
 Kainer, Herbert, 851 Boulevard, East, Weehawken (9)
 Kakascik, Emil J., 206 Palisade av., Garfield (2)
 Kalb, Samuel W., 416 Clinton pl., Newark (7)
 Kalter, George E., 640 Prospect st., Maplewood (7)
 Kanning, Fred'k R., 57 W. Allendale av., Al'dale (2)
 Kanes, Edmund S., 82 Bingham av., Rumson (13)
 Kaplan, Herman B., 324 44th st., Union City (9)
 Kaplan, S. Bernard, 846 S. 12th st., Newark (7)
 Kapp, Carl G., 440 Westminster av., Elizabeth (20)
 Karshmer, Ernest E., 927 S. Wood av., Linden (20)
 Karshmer, Nathan, 92 Carroll pl., New Brunswick (12)
 Kassow, Philip B., North Blvd., Alpha (21)
 Kastler, Franz, 54 Ames av., Rutherford (2)
 Katz, Herbert I., 278 Park av., Paterson (16)
 Katz, Jacob D., 115 Fairview av., Jersey City (9)
 Katzin, Eugene M., 50 Baldwin av., Newark (7)
 Kauffmann, Louis J., 228 N. 2nd st., Millville (6)
 Kaufman, Jerome G., 299 Clinton av., Newark (7)
 Kaufman, Michael J., 103 Lyons av., Newark (7)
 Kavanaugh, Daniel E., 566 Mt. Prosp't av., New'k (7)
 Kay, Clarence R., Main st., Peapack (18)
 Kazmann, Harold A., 406 Broadway, Long Br'nch (13)
 Kearney, Edw. P. J., 83 S. Fullerton av., Mntcl'r (7)
 Kearney, John F., 228 Hilton av., Maplewood (7)
 Keating, Chas. A., 177 Ellison st., Paterson (16)
 Keating, Joseph M., 275 Passaic av., Passaic (16)
 Keegan, Thomas D., 8 Gifford av., Jersey City (9)
 Keeney, Cadwell B., 137 Summit av., Summit (20)
 Keeney, James C., 1201 Park av., Hoboken (9)
 Keil, Sigmund S., 1182 St. George av., E., Linden (20)
 Keim, William F., 25 Roseville av., Newark (7)
 Keir, Floyd E., 308 Engle st., Englewood (2)
 Keith, Theodore R., 656 Bloomfield av., Nutley (7)
 Keller, Michael L., 673 E. 27th st., Paterson (16)
 Keller, Paul, 564 N. Edgemere dr., W. Allenh'rst (7)
 Kelley, Chas. B. P., 921 Bergen av., Jersey City (9)
 Kelly, Bernard S., 1954 Boulevard, Jersey City (9)
 Kelly, Harry R. J., 311A Brown st., Union City (9)
 Kelly, Leo J., 343 Barclay st., Perth Amboy (12)
 Kemeny, Imre, 48 Pulaski av., Carteret (12)
 Kemper, Harry T., 224 Monmouth rd., Elizabeth (20)
 Kennedy, A. Andrew, 6 Eagle av., Paterson (16)
 Kennedy, E. T., 413 Wanaque av., Pmptn. Lks. (16)
 Kennedy, John W., 12 Liberty pl., Weehawken (9)
 Kennedy, Paul A., 147 Tenaflly rd., Englewood (2)
 Kennedy, Wm. M., Essex Mountain Sana., Verona (7)
 Kenney, John A., Andrew Hosp., Tuskegee Inst., Ala. (7)
 Kerdasha, George S., 131 75th st., Woodcliff (9)
 Kerdasha, Richard F., 538 Benson st., Camden (4)
 Kern, E. Clarence, 45 Park st., Montclair (7)
 Kessell, John S., 643 Central av., East Orange (7)
 Kessler, Edward I., N. J. State Hosp., Gr'y'st'ne P'k (14)
 Kessler, Henry B., 666 Clinton av., Newark (7)
 Kessler, Henry H., 53 Lincoln Park, Newark (7)
 Keyser, David, 1518 Baird av., Camden (4)
 Kibbe, Milton H., 916 Park av., Plainfield (20)
 Kiely, Eugene M., 800 Hudson st., Hoboken (9)
 Kilduffe, Robt. A., Atlantic City Hosp., Atl. City (1)
 Kim, Gay B., 703 Main st., Paterson (16)
 Kimmel, Chas., 488 Broad st., Bloomfield (7)
 Kimmel, M. Leonard, 142 Manhattan av., Jer. C'y (9)
 Kimmel, Seymour S., Oxford (21)
 Kinczel, John A., 971 So. Broad st., Trenton (11)
 King, Alden P., 400 W. Blackwell st., Dover (14)
 King, Chester A., 412 Kinderkam'k rd., Oradell (2)
 Kingslow, George L., 346 1st st., Hackensack (2)
 Kinkead, Hilda, 56 Prospect st., Madison (14)
 Kinney, Albert G., 917 Haddon av., Collingsw'd (4)
 Kinney, Burton O., 41 Lincoln av., Little Falls (16)
 Kirkby, Cyril S., 45 Woodland st., Glen Ridge (7)
 Kirkman, Leroy G., 176 Roseville av., Newark (7)
 Kirschner, Martin I., Vernon (17)
 Kissinger, Donald J., 120 E. Madison av., Dumont (2)
 Kleiber, Estelle E., 131 Livingston av., N'w Bruns. (12)
 Klein, Alexander, 328 High st., Perth Amboy (12)
 Klein, Andrew J. V., 209 Littleton av., Newark (7)
 Klein, Edward C., Jr., 209 Littleton av., Newark (7)
 Klein, Edward F., 136 Market st., Perth Amboy (12)
 Klein, Henry L., Merck & Co., Rahway (20)
 Klein, Julius, 1415 Palisade av., Union City (9)
 Klein, William, 85 Bayard st., New Brunswick (12)
 Kleinberger, Harry H., 59 Main st., Millburn (7)
 Kleiner, Samuel, 162 Hamilton av., Paterson (16)
 Kleinman, Maurice, 101 Clinton av., Newark (7)
 Klempner, Paul, 637 Greenwood av., Trenton (11)
 Klenk, Joseph P., 328 Belleville av., Bloomfield (7)
 Kler, Joseph H., 151 Liv'gston av., New Brunswick (12)
 Kline, George L., 310 Mt. Prospect av., Newark (7)
 Kline, Herman, 2643 Pacific av., Atlantic City (1)
 Kline, Joseph J., 733 Hamilton av., Trenton (11)

- Kline, Oram R., 414 Cooper st., Camden (4)
 Klompus, Irving, 403 High st., Bound Brook (18)
 Klosk, Emanuel, 808 S. 12th st., Newark (7)
 Knapp, Rich'd E., 25 Hudson st., Hackensack (2)
 Knapp, Victor, 505 2nd av., Asbury Park (13)
 Knauer, Chas. H., Jr., 304 W. State st., Trenton (11)
 Knauer, George, 980 Elizabeth st., Elizabeth (20)
 Knight, Augustus S., Larger Cross rds., Peapack (18)
 Knight, Wm. T., 515 Oradell av., Oradell (2)
 Knowles, George M., 241 Main st., Hackensack (2)
 Knowles, James S., 316 N. 2nd st., Millville (6)
 Knox, Charles A., 138 Bergen av., Ridgefield Park (2)
 Knox, Harriet L., 390 Union st., Hackensack (2)
 Knox, Howard A., New Hampton (10)
 Kobes, John J., 138 Kearny av., Kearny (7)
 Koeck, George P., 625 Mt. Prospect av., Newark (7)
 Koesch, Fred'k J. E., 14 Kirkpatr'k st., N'w Brns. (12)
 Koenig, Bertram, 306 Broadway, Paterson (16)
 Koerber, George, 136 Prospect st., Passaic (16)
 Kohn, Joseph J., 207 Calhoun st., Trenton (11)
 Kohn, Ralph B., 207 Calhoun st., Trenton (11)
 Kohut, George J., 473 Amboy av., Perth Amboy (12)
 Kolb, John M., 725 10th st., Union City (9)
 Kolodin, Abraham, 98 Broad st., Bloomfield (7)
 Kondor, Joseph S., 978 S. Broad st., Trenton (11)
 Konzelman, Henry J., 65 King st., Hillside (20)
 Kooperman, Barnett, 321 60th st., W. New York (9)
 Kooperstein, Samuel I., 191 Palisade av., Jer. C'y (9)
 Koplin, A. Herman, 1239 Greenwood av., Trenton (11)
 Koplin, Nathaniel H., 142 W. State st., Trenton (11)
 Koppel, Joseph A., 42 Highland av., Jersey City (9)
 Kornfeld, Werner, 645 Central av., East Orange (7)
 Kosminsky, Louis, 30 W. Edsel Blvd., Palisades Pk (2)
 Kossmann, Walter J., Long Valley (14)
 Kovaleski, Walter A., 77 Market st., Passaic (16)
 Kovarsky, Albert E., 110 Market st., P'th Amboy (12)
 Kovin, Abraham, 123 Lexington av., Passaic (16)
 Kraemer, Manfred, 31 Lincoln Park, Newark (7)
 Kraemer, Samuel H., 309 Baldwin av., Jersey C'y (9)
 Krafchik, Louis L., 100 Bayard st., N'w Brunswick (12)
 Kraissl, Cornelius J., 393 Main st., Hackensack (2)
 Kraker, David A., 31 Lincoln Park, Newark (7)
 Kralik, Joseph J., 555 Market st., Newark (7)
 Kramer, Douglas W., 1019 Park av., Plainfield (20)
 Kramer, Samuel E., 254 State st., P'th Amboy (12)
 Krans, DeHart, 920 Park av., Plainfield (20)
 Krans, Edward S., 920 Park av., Plainfield (20)
 Kratka, Wm. H., 123 N. Pearl st., Bridgeton (6)
 Krauss, Fletcher I., 407 Main st., Chatham (14)
 Krausz, Emery, 577 S. Main st., Phillipsburg (21)
 Krehmer, Abraham, 521 Pacific av., Atlantic C'y (1)
 Kresch, Philip, 42 W. 22nd st., Bayonne (9)
 Kreutz, Paul J., 363 Union av., Elizabeth (20)
 Krichbaum, Carroll E., 63 Myrtle av., Montclair (7)
 Krohn, Marc, Campbell av., Belford (13)
 Kroll, Adolph, 103 Van Buren st., Passaic (16)
 Krone, William F., 31 Lincoln Park, Newark (7)
 Kruger, Alfred L., 100 Clifton pl., Jersey City (9)
 Kruger, William, 31 Lincoln Park, Newark (7)
 Kuchlewski, Edward J., 224 E. Jersey st., Elizab'h (20)
 Kuder, Joseph M., 104 Garden st., Mt. Holly (3)
 Kuhl, John P., 38 Main st., Butler (16)
 Kuhlmann, Alvin E., 527 37th st., Union City (9)
 Kuite, George B., 435 Speedwell av., Morris Plains (14)
 Kummel, Max., 31 Lincoln Park, Newark (7)
 Kump, Albert B., 31 W. Commerce st., Bridgeton (6)
 Kun, Bertram, 135 Belmont av., Jersey City (9)
 Kushner, Alexander, 208 W. Milton av., Rahway (20)
 Kustrup, John F., 1418 S. Broad st., Trenton (11)
 Kutner, Charles, 1005 S. 5th st., Camden (4)

ASSOCIATE MEMBERS

- Kaplan, Henry L., 24 Johnson av., Newark (7)
 Kosterlitz, Henry H., 1144 Clinton av., Irvington (7)
 Krieger, George, 269 Broadway, Passaic (16)
 Kunz, Harold G., 82 W. Passaic av., Bloomfield (7)
 Kuperman, Henry L., 25 Van Velsor pl., Newark (7)

L

ACTIVE MEMBERS

- Laaue, Harold W., 198 Haledon av., Prosp't P'rk (16)
 Labash, Charles S., 83 Quincy st., Passaic (16)
 Labow, Joseph J., 757 N. Broad st., Elizabeth (20)
 Ladas, George, 305 Cherry st., Elizabeth (20)
 Lafferty, Elton B., 330 Myrtle av., Irvington (7)
 Laird, George S., 127 Central av., Westfield (20)
 Lakiszak, Roman T., 253 Stegman st., Jersey C'ity (9)
 Lamberto, Vito A., 422 Stuyvesant av., Lyndh'rst (2)
 Lance, Elton W., 125 W. Milton av., Rahway (20)
 Landaw, Louis, 631 E. 26th st., Paterson (16)
 Landes, Edwin W., Stillwater (19)
 Landesman, William, 187 Kearny av., Kearny (7)
 Landis, Harry P., Jr., 925 Columbia av., Palmyra (3)
 Landshof, Charles A., 50 Glenwood av., Jer. City (9)
 Lane, Austin W., 98 Prospect st., East Orange (7)
 Lane, Edgar W., 46 Main st., Bloomsbury (10)
 Lane, Thomas F., 145 Garrison av., Jersey City (9)
 Lang, Joseph, 111 Market st., Perth Amboy (12)
 Lange, Louis C., 50 Clifton ter., Weehawken (9)
 Lapin, Louis P., 15 Crosswicks st., Bordentown (11)
 Lapin, Samuel B., 542 W. State st., Trenton (11)
 Largay, Arthur O., 937 Ave. C, Bayonne (9)
 Larkey, Charles J., 700 Ave. C, Bayonne (9)
 Larossa, Ernest A., 640 Federal st., Camden (4)
 Larrabee, Callie H., 24 Hobart av., Summit (20)
 Larson, Henry M., 35 Franklin st., Morristown (14)
 Larsson, Evert A., N. J. State Hosp., Trenton (11)
 Lasley, James M., N.J. State Hosp., Greyst'ne Pk. (14)
 Lathrop, Frederic W., 909 Park av., Plainfield (20)
 Lathrope, George H., 965 Broad st., Newark (14)
 Latona, Joseph A., 78 Main st., Lodi (2)
 Laudig, Guy H., 361 Speedwell av., Morris Plains (14)
 Laurie, Andrew L., 664 Newark av., Elizabeth (20)
 Lavine, Barney D., 630 N. Clinton av., Trenton (11)
 Lavine, Sidney B., 144 W. State st., Trenton (11)
 Lawrence, Elias D., 365 Union av., Paterson (16)
 Lawrence, Wm. H., 129 Summit av., Summit (20)
 Lawsing, G. Conde, 443 22nd st., W. New York (9)
 Lawther, Boyd M., 1401 Shore rd., Northfield (1)
 Lawton, A. Anderson, 15 N. Bridge st., Somerville (18)
 Lazow, S. Manlius, 199 Main st., Matawan (12)
 Leach, John E., 372 Park av., Paterson (16)
 Leaman, Granville M., 167 N. Grove st., E. Orange (7)
 Leaver, Morris H., Quakertown (10)
 Le Bel, Louis J. B., 165 Grant av., Nutley (7)
 Leber, Otto H., 56 Church st., Montclair (7)
 Lee, Frederick P., 606 E. 27th st., Paterson (16)
 Lee, John J., 309 Park av., Orange (7)
 Lee, Stephen G., 55 Halsted st., East Orange (7)
 Lee, Thomas B., 622 Cooper st., Camden (4)
 LeFavor, Dean H., 619 Morgan av., Palmyra (3)
 Lefkowitz, Jacob H., 445 64th st., West New York (9)

- Legato, Samuel F., 417 Palisade av., Cliffside Pk(2)
 Leggett, Lindley H., Jr., 330 E. Broad st., Westfd(20)
 Leggett, Thos. H., Jr., 706 Park av., Plainfield (20)
 Lehmacher, Frank, 16 Central av., Lakewood (15)
 Leibovitz, Altan C., 261 Lexington av., Passaic (16)
 Leighton, Robert L., 401 Ludlow av., Spring Lake(13)
 Leining, Albert, 45 48th st., Weehawken (9)
 Leir, J. Krevin, 9 Garrison av., Jersey City (9)
 Lemay, Albert T., 532 14th av., Paterson (16)
 Lemkin, Samuel, 71 Pomona av., Newark (7)
 Lemmerz, Theodore H., 141 Magnolia av., Jer. Cy(9)
 Lemmerz, W. H., 184 Hack'n'sk st., Wood-Ridge (2)
 Lemmon, Junius M., 28 W. W'sh'gt'n av., W'sh'gt'n(21)
 Leonard, George F., 63 N. 5th av., Highl'd Park (12)
 Leonard, Isaac E., 2842 Atlantic av., Atlantic City(1)
 Leonard, Isaac E., Jr., 2842 Atl. av., Atlantic City(1)
 Leonard, Lothair L., 615 Asbury av., Asbury Park(13)
 Leonardis, James V., 94 Jefferson st., Newark (7)
 Lepree, Joseph A., 371 Morris av., Elizabeth (20)
 Lerman, Irving, 1024 E. Jersey st., Elizabeth (20)
 Leshin, Harry, 564 S. Main st., Hightstown (11)
 Lesko, Stephen W., 234 Mt. Pleasant av., Wall'gt'n(2)
 Lettiere, Anthony J., 425 E. State st., Trenton (11)
 Levensky, Daniel E., 52 Market st., Passaic (16)
 Levin, Jack, 45 E. Main st., Freehold (13)
 Levin, Joseph, 831 S. 13th st., Newark (7)
 Levin, Louis, 651 W. State st., Trenton (11)
 Levine, Edward P., 86 Clinton av., Newark (7)
 Levine, G. Irving, 2017 Hudson Blvd., Jersey City(9)
 LeVine, Israel, 215 Broadway, Paterson (16)
 Levine, Philip, New'rck Beth Israel Hosp., Newark(7)
 Levine, Sidney C., 459 Park av., Paterson (16)
 Levinsohn, Sandor A., 656 E. 29th st., Paterson (16)
 Levinson, Louis J., 18 Stratford pl., Newark (7)
 Levinson, Reuben, 241 State st., Perth Amboy (12)
 Levinson, Robert M., 859 S. 13th st., Newark (7)
 Levinson, William, 75 Lincoln Park, Newark (7)
 Levitas, George M., 77 Fairview av., Westwood (2)
 Levitas, Irving M., 77 Fairview av., Westwood (2)
 Levitt, Jesse N., 26 Clinton pl., Newark (7)
 Levy, Abram, 1120 W. 7th st., Plainfield (18)
 Levy, Anna L., 260 Meeker av., Newark (7)
 Levy, Herman, 219 Lexington av., Passaic (16)
 Levy, Irvin, 154 W. State st., Trenton (11)
 Levy, Jack D., 191 Union st., Hackensack (2)
 Levy, Julius, 19 Lyons av., Newark (7)
 Lewandowski, Edmund E., 665 Grove st., Irv'gt'n(7)
 Lewis, Albert, 41 Retford av., Cranford (20)
 Lewis, Alice B., E. Saddle River rd., Saddle River(2)
 Lewis, G. Rae, 458 Washington av., Belleville (7)
 Lewis, Jacob, 43 Court st., Freehold (13)
 Lewis, Leon, 190 Clinton av., Newark (7)
 Lewis, Thomas K., 47 S. 27th st., Camden (4)
 Liana, Stephen M., 48 Market st., Passaic (16)
 Liccese, Emanuel, 84 Jefferson st., Newark (7)
 Licks, Fred'k C., 117 Irvington av., S. Orange (7)
 Lieb, Saul, 337 Hawthorne av., Newark (7)
 Lieberman, David P., 597 W'stminster av., Elizab'h(20)
 Lieberman, Milton L., 101 Pershing av., Roselle Pk(20)
 Lief, Lawrence H., Gatzner av., Jamesburg (12)
 Lifland, Bernard D., 35 Shanley av., Newark (7)
 Light, Arthur B., Lawrencev'e Sch., Lawrenceville(11)
 Lihn, Barney, 611 Elmer st., Vineland (6)
 Lilien, Bernard B., 730 Lyons av., Irvington (7)
 Lilien, Milton M., 152 Clark st., Hillside (20)
 Linares, A. Carli, 208 Market st., Paterson (16)
 Lincoln, Jennings S., 140 Watchung av., Up.Mtclr.(7)
 Linden, Mortimer H., 45 Clendenny av., Jer. City(9)
 Lindroth, Lawrence V., 4633 Hud. Blvd., N. Bergen(9)
 Linke, James J. P., 245 E. Front st., Plainfield (20)
 Lintz, Sidney Z., 447 Kings Hwy., Swedesboro (8)
 Lipkin, Isadore, 157 W. Main st., Pennsgrove (17)
 Lipshutz, Benjamin, 18 W. 22nd st., Bayonne (9)
 Lipshutz, Charles, 804 Ave. C, Bayonne (9)
 Lipstein, William, 845 Chancellor av., Irvington (7)
 Lipton, Louis, 67 Passaic av., Passaic (16)
 Little, Alonzo W., 120 Arlington av., Jersey City(9)
 Little, Wm. R., 493 W. State st., Trenton (11)
 Littwin, Chas., 950 Queen Anne rd., Teaneck (2)
 Liva, Arcangelo, 5 Pangborn pl., Hackensack (2)
 Liva, G. Albin, Madison av., Wyckoff (2)
 Liva, Paul F., 280 Stuyvesant av., Lyndhurst (2)
 Livengood, Baxter A., 64 Cooper st., Woodbury (8)
 Livengood, Horace R., 587 Westminster av., Eliz.(20)
 Livingston, Paul, 299 Main st., East Orange (7)
 Lloyd, Samuel J., 178 W. State st., Trenton (11)
 Llull, Gabriel J., 266 Morris av., Springfield (20)
 Lobban, Robert B., 2595 Boulevard, Jersey City (9)
 Lobsenz, Nathan P., 294 Broadway, Paterson (16)
 Loder, Horace B., 225 E. Commerce st., Bridgeton(6)
 Loder, Joseph S., 924 S. 17th st., Newark (7)
 Loeb, William A., Vets. Administration, Lyons (18)
 Loeser, Lewis H., 31 Lincoln Park, Newark (7)
 Loksa, Harold T., 520 Washington st., Boonton (14)
 Loman, Samuel G., 130 Magnolia av., Cresskill (2)
 Lamauro, James R., 145 Lexington av., Passaic (16)
 Lombardi, Frank L., 25 E. Clinton av., Bergen'd(2)
 London, Jules R., 153 Jefferson st., Passaic (16)
 London, Russell I., 288 Massachusetts av., Atl. Cy(4)
 London, William, 255 State st., Perth Amboy (12)
 Londrigan, Jos. F., 832 Bloomfield st., Hoboken (9)
 Londrigan, Jos. F., II, 832 Bloomfield st., Hobok'n(9)
 Long, Miles T., 2150 Boulevard, Jersey City (9)
 Long, Pauline A., 22 Livingston av., N'wBruns.(12)
 Longnecker, John E., Jr., Sparta (19)
 Longsdorf, Harold D., Mount Holly (3)
 Looi, Wm. A., 549 Pavonia av., Jersey City (9)
 Lord, C. Donald, 496 S. Maple av., Glen Rock (2)
 Lore, Harry E., Main st., Cedarville (6)
 Lorenzo, Michael J., 75 Riverside av., Red Bank (13)
 Lottridge, Dorothy, 43 S. Maple av., E. Orange (7)
 Loux, Henry A., 40 Main st., Sussex (19)
 Love, Elizabeth F., 142 E. Oak av., Moorestown (3)
 Lovejoy, James L., 224 Somerset st., B'd Brook(18)
 Lovell, Frederick H., 1011 Clinton av., Irvington(7)
 Lovell, John F., 1011 Clinton av., Irvington (7)
 Lovett, Jos. C., Municipal Hosp., Camden (4)
 Low, Donald B., 529 Broadway, Paterson (16)
 Lowell, Milton E., 434 Summit av., Westfield (20)
 Lowenstein, Aaron, 860 S. 11th st., Newark (7)
 Lowenstein, Ernest C., 1492 Main st., Rahway (20)
 Lowenstein, Harry A., 96 Milford av., Newark (7)
 Lowrey, James H., 79 Congress st., Newark (7)
 Lowy, Otto, 190 Clinton av., Newark (7)
 Luban, Benjamin, 730 High st., Newark (7)
 Lucas, W. Fred, 23 W. Broad st., Burlington (3)
 Lucent, S. Bell, 2 First st., Little Falls (16)
 Luczynski, Edward W., 28 E. 22nd st., Bayonne (9)
 Lueddecke, Roland E., 216 Randolph av., E.R'th'rf'd(2)
 Lufburrow, Chas. B., 441 W. Front st., Plainfield(20)
 Luippold, Eugene J., 85 Columbia ter., Weehawk'n(9)
 Luippold, E. J., Jr., 318 Washington st., Boonton(14)
 Luksteid, Casimir J., 326 Park av., Paterson (16)
 Lummis, Clarence P., 40 Delaware av., Pennsgr.(17)
 Lund, John L., 267 High st., Perth Amboy (12)
 Lundblad, Walter E., 75 Prospect st., E. Orange (7)
 Luongo, Federico, 212 S. Centre st., Orange (7)
 Lupin, Edward E., 727 Ave. C, Bayonne (9)
 Luria, Sanford A., 249 Queen Anne rd., Bogota (2)
 Lurie, Solomon I., 21 Hillside av., Newark (7)
 Lurie, Wolf, 493 Watchung av., Bloomfield (7)
 Lushear, Frank H., Branchville (19)
 Lussier, George H., N. J. State Hosp., Marlboro(13)
 Lutz, William M., 3 Southern Slope dr., Millburn(7)
 Lysterly, James M., 121 E. 7th st., Plainfield (20)
 Lynch, Donald C., 178 W. State st., Trenton (11)
 Lynch, Edward T., 748 Livingston rd., Elizabeth(20)
 Lynch, Maurice M., 396 Union st., Hackensack(2)
 Lynch, Roland J., Mental Dis. Hosp., Secaucus (9)
 Lynn, Irving I., 2252 Boulevard, Jersey City (9)

- Lyon, Archibald, 115 Ridge rd., N. Arlington (7) Lyon, Earl C., 194 E. Commerce st., Bridgeton (6)
Lyon, Charles H., South Main st., Phillipsburg (21) Lyons, James V., 333 Park av., Orange (7)
Lyons, Romola L. K., 171 Mead'wbr'k rd., Englew'd (2)

ASSOCIATE MEMBERS

- Landau, Maurice, 839 King George's rd., Fords (12) Levin, Murray, 96 Washington st., W. Orange (7)
Larkey, Irving G., 95 Shanley av., Newark (7) Lewis, Collins E., 293 Commercial av., N'wBruns.(12)
Lavine, Samuel C., 1207 So. Clinton av., Trenton(11) Linn, Louis, N. J. State Hospital, Trenton (11)
Lawrence, Arthur C., Box 21, Main st., Lincoln Pk(16) Lomhoff, Irving I., Essex Mt. Sana., Verona (7)
Lucey, James J., 184 Market st., Perth Amboy (12)

M

ACTIVE MEMBERS

- Maas, Max A., 329 Clinton av., Newark (7) Manahan, Daniel V., 55 E. Front st., Red Bank (13)
Mabey, J. Corwin, 242 Claremont av., Montclair (7) Mancene, Edward M., 145 Marshall av., Little Ferry (2)
MacAlistar, Wm. W., 171 Carroll st., Paterson (16) Mancusi-Ungaro, Elviro, 268 Mt.Pr'sp't av., Nwk.(7)
MacAlpine, K. B., 308 Monm'th st., Gloucester City(4) Mancusi-Ungaro, Lodovico, 156 Mt.Pr'sp't av., Nwk.(7)
Macaluso, Dominic C., 7 Hilton st., Belleville (7) Mangelsdorff, Arthur F., Calco Chem.Co.B'dBr'k(18)
MacArt, James H., 74 S. Munn av., E. Orange (7) Mango, Concetta G., 1 75th st., North Bergen (9)
MacArthur, Clymont, 219 Roseville av., Newark (7) Mangone, Geo. F., 811 Palisade av., Union City (9)
Macaulay, Francis A., 815 Elm av., Teaneck (2) Manly, Thos. E., 390 Park av., Paterson (16)
MacBrayer, R. A., Ciba Co., Lafay'te P'k, Summit(20) Mann, Benjamin, 468 Brace av., Perth Amboy (12)
Macchia, Benjamin J., 358 Arlington av., Jer.City(9) Mann, Jacob J., 255 State st., Perth Amboy (12)
MacDermid, Lynden E., 506 F'rns'w'th av., B'rd'nt'n(11) Manzione, Frank A., 500 Union av., Paterson (16)
MacDonald, John J., 348 Ogden av., Jersey City (9) Maps, Howard L., 53 Passaic av., Passaic (16)
Macdonald, Wentworth S., 56 Church st., Montcl'r(7) Maras, Peter E., 80 Tonnele av., Jersey City (9)
MacDowall, John L., 113 Market st., P'hAmboy(12) Marcarian, Henry G., 904 Cooper st., Camden (4)
Mace, Margaret, 2410 Atlantic av., N. Wildwood (5) Marchione, Nicholas E., 109 S. 7th st., Vineland (6)
MacGregor, Allan W., 379 Ellison st., Paterson (16) Marcus, Donald, 640 Stuyvesant av., Irvington (7)
MacGuffie, Robert N., 657 Main av., Passaic (16) Marey, John W., 117 E. Park av., Merchantville (4)
Maciejewski, Anthony S., 212 VanBuren st., N'w'k(7) Margaretten, Edward I., 263 High st., P'thAmboy(12)
Mackler, Meyer E., 575 Broadway, Paterson (16) Margolin, Samuel J., 1012 80th st., No. Bergen (9)
MacKellar, James M., 26 E. Clinton av., Tenafly (2) Margolis, Alfred, 218 W. End av., Newark (7)
MacKenzie, Robert A., 501 Grand av., Asbury P'k(13) Margulies, Charles, 188 High st., Nutley (7)
Mackes, Claude B., 48 N. Main st., Woodstown (17) Marini, Dominick, 40 Henry st., Passaic (16)
Mackin, John J., 596 Bergen av., Jersey City (9) Mark, Harry B., Riverton (3)
MacLaren, Philip J., 397 Kinderkam'k rd., Westw'd(2) Mark, Joseph S., 102 Green st., Woodbridge (12)
MacLay, Joseph A., 239 Broadway, Paterson (16) Markel, Albert G., 450 Park av., Paterson (16)
MacMillan, Wright, 4 Duryea rd., Up. Monclair (7) Markley, Luther A., Holy Name Hosp., Teaneck(2)
Macpherson, Elwood H., 34 Rawley pl., Millburn (7) Markowitz, Benjamin B., 2157 Hud. Blvd., Jer.City(9)
Madaras, John S., 870 Ave. C, Bayonne (9) Markowitz, Irwin B., 2157 Hud. Blvd., Jersey City(9)
Madden, Leland S., 21 E. Verona av., Pl's'tville (1) Markowitz, Louis, 380 Park av., Paterson (16)
Madden, Theophilus W., 16 Frazier av., Collingsw'd(4) Marks, Edward G., 655 Kearny av., Arlington (7)
Madden, William L., 83 Gifford av., Jersey City (9) Marks, Zelda I., 95 Wilson av., Newark (7)
Maddren, Russell F., 322 Park st., Hackensack (2) Marlett, Neumann C., 230 Greenwich st., Belvidere(21)
Mader, A. Ivan, Jr., 430 Union st., Hackensack (2) Marone, Carmine R., 648 1st av., Elizabeth (20)
Madison, Lewis K., 358 Pacific av., Jersey City (9) Maroney, James H., 129 Summit av., Summit (20)
Maffongelli, Joseph A., 494 River st., Paterson (16) Marquis, Dean W., 144 Harrison st., E. Orange (7)
Magee, Edward S., 604 White Horse Pk., Oaklyn(4) Marquis, W. James, 198 Clinton av., Newark (7)
Magee, Harold S., N. J. State Hosp., Trenton (11) Marra, Rocco S., 221 Park av., Orange (7)
Magee, Henry R., 55 John st., New York City (2) Marsh, Elias J., 400 Van Houten st., Paterson (16)
Magee, Russell S., 201 White Horse Pk., Audubon(4) Marshall, H. Donald, 611 N. Indiana av., Atl. City(1)
Magennis, Bryan C., 270 Broadway, Paterson (16) Martin, Leonard J., 206 Prospect av., Asbury P'k(13)
Maggio, George A., 110 Fleming av., Newark (7) Martin, Theodore, 577 Lincoln av., Glen Rock (16)
Maggio, Ross J., 206 Park av., Westfield (20) Martin, Wm. P., 25 Holland rd., So. Orange (7)
Magill, Marcus, 4116 Ventnor av., Atlantic City (1) Martland, Harrison S., City Hosp., Newark (7)
Magnes, Max, 271 Park av., Paterson (16) Marts, George H., 956 Park av., Plainfield (20)
Magolda, Anthony F., 727 Grape st., Vineland (6) Marvin, Dorothy H., 51 Livingston av., N'wBruns.(12)
Magovern, Thos. F., 228 S. Orange av., S. Orange(7) Marx, Frederick J., 486 Churchill rd., W.Englew'd(2)
Magson, Albert E., 302 S. Main st., Hightstown (11) Mason, Howard B., 90 W. Main st., Freehold (13)
Mahaffey, J. Lynn, 406 Warwick rd., Haddonf'd (4) Mason, James H., 1616 Pacific av., Atlantic City (1)
Mahood, Herbert L., 86 Durand rd., Maplewood (7) Mason, Virgil A., 144 Harrison st., E. Orange (7)
Majeski, Henry J., 935 Brunswick av., Trenton (11) Massengill, Fulton, 802 Livingston rd., Elizab'th(7)
Major, Morton M., 4212 Ventnor av., Atl. City (1) Massey, J. Bruce, 20 Codwise av., NewBrunsw'k(12)
Makin, John B., 501 Grand av., Asbury Park (13) Masterson, John F., 98 Myrtle av., Irvington (7)
Malatesta, Chas. S., 1203 Martine av., Plainfield(20) Mastroianni, Frank M., 901 Colonial av., Union (20)
Maldeis, Albertos M. K., 117 N. 6th st., Camden (4) Mastromonaco, Jos. D., 790 Ave. C, Bayonne (9)
Mamlet, Alfred M., 16 Johnson av., Newark (7) Masucci, Alberico, 128 Carroll st., Paterson (16)

- Matera, Joseph, 506 Garden st., Hoboken (9)
 Matheke, George A., 592 Park av., East Orange (7)
 Matheke, Otto G., 328 Sussex av., Newark (7)
 Matheke, Otto G., Jr., 328 Sussex av., Newark (7)
 Mathesheimer, Jacob L., 280 Old Br'g'n rd., Jer. Cy' (9)
 Matheson, Gilchrist E., 144 S. Harris'n st., E. Or'ge (7)
 Mathews, Raymond H., 186 South st., Morrist'n (14)
 Mathews, Wm. J., 938 Hudson st., Hoboken (9)
 Matthews, Clifford B., 1180 Raymond Blvd., N'w'k (7)
 Matthews, Harry E., 504 Hillside av., Orange (7)
 Matthews, Leonard M., 655 Main av., Passaic (16)
 Matthews, William, 139 Broad st., Red Bank (13)
 Matthews, Wm. F., 61 S. Fullerton av., Montcl'r (7)
 Matturri, Dominick A., 81 Gifford av., Jersey City (9)
 Maturi, Vincenzo E., 814 Hudson Blvd., Bayonne (9)
 Maurer, K. Virginia, 26 W. North'd av., Liv'gst'n (7)
 Maver, William W., 532 Bergen av., Jersey City (9)
 May, Ernst A., 157 Harrison st., East Orange (7)
 Mayhew, Charles H., 329 Pine st., Millville (6)
 McAlpine, Paul, 129 Summit av., Summit (20)
 McBride, Andrew F., 30 Church st., Paterson (16)
 McBride, Andrew F., Jr., 655 Br'dw'y, Paterson (16)
 McBride, Hesser G., 1072 S. Orange av., Newark (7)
 McCall, Jesse, 9 Linwood av., Newton (19)
 McCallion, Wm. H., 722 Westminster av., Elizab'h (20)
 McCallum, Arthur S., 213 Cl'm'ts Br. rd., Barr'gt'n (4)
 McCamey, Kenneth E., 612 E. 29th st., Paterson (16)
 McCandliss, Wm. K., N. J. State Hosp., Trenton (11)
 McCarroll, E. Mae, 59 Hillside pl., Newark (7)
 McCarron, James A., 341 Ave. A, Bayonne (9)
 McCarthy, Arthur M., 2772 Federal st., Camden (4)
 McCarthy, Cornelius P., 887 Blvd., Bayonne (9)
 McCarthy, George L., 506 Union av., Paterson (16)
 McCarthy, John J., 1001 79th st., N. Bergen (9)
 McCarthy, Wm. P., 1203 Parkside av., Trenton (11)
 McCauley, Francis J., 31 Lincoln Park, Newark (7)
 McCluskey, Harry B., Morristown rd., Whipp'ny (14)
 McConaghy, Thos P., 10th & Cooper sts., Camden (4)
 McConaughy, Francis, 1 E. High st., Somerville (18)
 McCorkle, William E., Ringoes (10)
 McCormack, Frank C., 95 Tenafl'y rd., Englew'd (2)
 McCormick, James E., 775 Elizabeth av., Newark (7)
 McCormick, Wm. H., Jr., 266 Market st., Ph'Amb'y (12)
 McCoy, John C., 292 Broadway, Paterson (16)
 McCreight, David W., N. J. State Hosp., Marlboro (13)
 McCroskery, James H., 396 N. Arlington av., E. Or. (7)
 McCue, John B., 912 Lincoln av., Pompton Lks. (16)
 McCullough, John H., 523 E. State st., Trenton (11)
 McCullough, Walter A., Essex Co. Hosp., Cedar Gr. (7)
 McDede, Frank F., 922 Main st., Paterson (16)
 *McDede, J. Searle, 215 Ege av., Jersey City (9)
 McDermott, Vincent T., 511 State st., Camden (4)
 McDonald, Frank R., 37 Monticello av., Jer. City (9)
 McDonald, Richard J., 80 Park av., Paterson (16)
 McDonnell, Gerald E., 200 Garden st., Mt. Holly (3)
 McDonnell, George J., 80 W. Main st., Freehold (13)
 McElroy, Ervin, 20 Main st., Rockaway (14)
 McFeely, Percy R., 242 Palisade av., Bogota (2)
 McGeary, John A., 610 Salem av., Elizabeth (20)
 McGinn, Wm. J., 1913 Westfield av., Scotch Pl'ns (20)
 McGivern, Chas. S., 805 Pacific av., Atlantic City (1)
 McGlade, Thos. H., 2953 Yorkship Sq., Camden (4)
 McGovern, John F., Jr., 24 Liv'gst'n av., N'w Brswk. (12)
 McGuigan, Francis A., 212 N. Warren st., Tr'nt'n (11)
 McGuire, John J., 2 Gould av., Newark (7)
 McGuire, Joseph T., 77 Autumn st., Lodi (2)
 McKelvie, Julius C., 55 Rockwell av., L'g Br'nch (13)
 McKiernan, Robt. L., 97 Bayard st., N'w Bruns. (12)
 McKim, William F., 317 Roseville av., Newark (7)
 McKinstry, John W., Railroad av., Jamesburg (12)
 McLane, A. Donald, 498 Engle st., Englewood (2)
 McLean, Herbert E., 92 Fairview av., Jersey City (9)
 McLean, Hugh A., 414 17th st., W. New York (9)
 McLellan, George A., 19 Hawthorne av., E. Orange (7)
 McLeod, Harry J., 71 Forest rd., Tenafl'y (2)
 McLoughlin, Frank J., 558 Jersey av., Jersey City (9)
 McLoughlin, John W., 39 W. 26th st., Bayonne (9)
 McMahon, Bernard C., 18 DeHart st., Morrist'n (14)
 McMurray, Geo. B., N.J. State Hosp., Gr'y'st'n P'k (14)
 McMurtrie, Wm. A., 20 Franklin st., Morristown (21)
 McNenney, Claudio E., 113 Fairview av., Jer. City (9)
 McPherson, M. E., 141 Diamond Br. av., H'wth'ne (16)
 McTague, Robt. S., 88 3rd av., Atl. Highlands (13)
 McVay, Edward A., 234 Lafayette st., Newark (7)
 McVeigh, Charles J. D., Netcong (19)
 McWilliams, Charles E., Blackwood (4)
 Meacham, Eugene A., 112 N. Stevens av., S. Amboy (12)
 Means, Paul B., N. J. State Hospital, Trenton (11)
 Mears, Wm. G., 222 Overlook av., Leonia (2)
 Mecray, Paul M., 405 Cooper st., Camden (4)
 Mecray, Paul, Jr., 405 Cooper st., Camden (4)
 Medd, John C., 25 Curtis pl., Maplewood (7)
 Meehan, George E., 117 Mercer st., Jersey City (9)
 Meehan, Martin M., 339 Wash'gt'n av., Belleville (7)
 Meeker, Irving A., 581 Valley rd., Up. Montclair (7)
 Meeker, John L., 6 DeBarry pl., Summit (20)
 Meier, Wm. U., 1062 Ringwood av., Haskell (16)
 Meineke, Wm. C., Jr., 818 Chestnut st., Roselle (20)
 Meinzer, Martin S., 147 Market st., Perth Amboy (12)
 Mellen, Stanley H., Livingston Bldg., Livingston (7)
 Meloney, Lester F., 156 Second st., Clifton (16)
 Meltsner, Louis, 904 Hudson st., Hoboken (9)
 Meltzer, Louis, 32 W. 33rd st., Bayonne (9)
 Mendelsohn, David H., 576 Broadway, Paterson (16)
 Mendenhall, Clinton D., 412 F'rns'w'th av., Br'd't'n (3)
 Meneve, Alfred D., 373 Broadway, Paterson (16)
 Menge, Carl H., 236 Washington st., Toms River (15)
 Mengel, Willard G., 400 Penn st., Camden (4)
 Menk, Paul E., 31 Lincoln Park, Newark (7)
 Merkelbach, Walter P., 288 Broad st., Bloomfield (7)
 Merliss, Eugene, 386 Clinton av., Newark (7)
 Merlo, Francis A., 210 Murray st., Elizabeth (20)
 Merlo, Francis V., 39 3rd st., Elizabeth (20)
 Merselis, John G., 110 Irvington av., S. Orange (7)
 Mersheimer, Christian H., 15 Reservoir av., Jer. Cy' (9)
 Metz, Henry, 5 Pangborn pl., Hackensack (2)
 Metzger, Emma P. W., 430 Fairview st., Riverside (3)
 Metzger, Freeman W., 428 Fairview st., Riverside (3)
 Metzger, Karl F., 401 Fifth av., Belmar (13)
 Meurlin, Alfred, 158 S. Harrison st., E. Orange (7)
 McVay, James C. F., 2907 Pacific av., Atlantic Cy' (1)
 Meyer, Eugene A., 407 Chester av., Moorestown (3)
 Meyer, George P., 410 Haddon av., Camden (4)
 Meyer, Howard M., 400 Maple Hill dr., Hackens'k (2)
 Meyer, William, 2128 New York av., Union City (9)
 Meyerson, Noah, 428 59th st., West New York (9)
 Mezzetti, Alfred F., 220 S. 6th st., Vineland (6)
 Michela, Luigi S., 206 Carroll st., Paterson (16)
 Michell, George E., 221 High st., Hackettstown (14)
 Mickewich, Stephen A., 650 Ave. C, Bayonne (9)
 Miele, Frank A., 314 Carr av., Keansburg (13)
 Mierau, Ernest W., 1096 Sanford av., Irvington (7)
 Miller, Earle K., 2502 Nottingham way, Trenton (11)
 Miller, Gerald H., N. Main st., Cranbury (11)
 Miller, H. Garrett, 203 E. Main st., Millville (6)
 Miller, Herman P., 815 S. 12th st., Newark (9)
 Miller, I. Irwin, 675 Sanford av., Newark (7)
 Miller, Jos. A., 364 Prospect st., So. Orange (7)
 Miller, Lewis H., 37 S. Main st., Woodstown (17)
 Miller, Max H., 311 16th st., West New York (9)
 Miller, Nathan, 861 Lyons av., Irvington (7)
 Miller, Robert M., 382 Springfield av., Summit (20)
 Miller, Samuel R., 407 S. Main st., Pennington (11)
 Miller, William H., 37 S. Main st., Woodstown (17)
 Mills, Charles S., 106 Lippincott av., Riverton (3)
 Mills, Clifford, 36 Maple av., Morristown (14)
 Mills, Stephen D., 132 S. Euclid av., Westfield (20)
 Milnis, Bernard, 100 74th st., Woodcliff (9)
 Minard, Edwy L., 140 4th av., East Orange (7)
 Minier, Carl L., 153 Mt. Pleasant av., W. Orange (7)

Miningham, Wm. D., 18 Hedden ter., Newark (7)
Minnefor, Charles A., 1164 S.Orange av.,S.Orange(7)
Minnella, Thomas J., 132 Morris av., Summit (20)
Minschwaner, Geo. G., Jr., 954Gr'nw'd av.,Tr'nt'n(11)
Mishell, Daniel R., 31 Lincoln Park, Newark (7)
Mishler, Jay E., 805 Pacific av., Atlantic City (1)
Missonellie, Wm., 404 Lafayette av., Hawthorne (16)
Mitchell, Augustus J., 59 South st., Newark (7)
Mitchell, Chas. H., 1100 W. State st., Trenton (11)
Mitchell, Charles R., 311 Broadway, Paterson (16)
Mitskas, Theodore V. J., 704 Gr'nw'd av.,Trenton(11)
Mockett, Walter W., 714 Palisade av., Grantw'd (2)
Modrys, W. F., 1400 Palisade plaza, Hudson Hgts.(2)
Moeckel, C. W., 63 S. Fullerton av., Montclair (7)
Moffat, Barclay W., Nut Swamp rd., Red Bank (13)
Mohrbacher, John J., 37 Osborne ter., Newark (7)
*Moister, Roger W., 30 Beechwood rd., Summit (20)
Molitch, Matthew, 705 Pacific av., Atlantic City (1)
Monaco, Saverio A., 293 Camden st., Newark (7)
Monasson-Friedland, Ida, Woodbine (5)
Monfort, Robert N., 155 Van Wagenen av.,Jer.C'y(9)
Montfort, Robert J., 1051 E. Jersey st., Elizabeth(20)
Moon, Alexander C., Cape May (5)
Moore, Dean C., 138 N. Arlington av., E. Orange (7)
Moore, Ralph L., 127 N. Broad st., Woodbury (8)
Mores, Herbert R., 65 Bergen av., RidgefieldP'k(2)
Moress, Edward J., 1524 Maple av., Hillside (7)
Moretti, John J., 576 S. Clinton st., E. Orange (7)
Morgan, Browne, 32 Benson st., Bloomfield (7)
Morici, Theodore, 80 Howe av., Passaic (16)
Moriconi, Albert F., 438 Hamilton av., Trenton (11)
Morley, Grace C., 64 Clifton ter., Weehawken (9)
Morrill, James P., 310 Broadway, Paterson (16)
Morris, Carlyle, Spring st. & Lake av.,Metuchen(12)
Morris, Clement, 513 Broadway, Newark (7)
Morris, David G., 11 W. 26th st., Bayonne (9)
Morris, Nathan, 40 Grove st., No. Plainfield (18)
Morris, Thomas M., 505 Park av., Plainfield (20)
Morris, Watson B., 193 Morris av., Springfield (20)
Morrison, Caldwell, 379 7th av., Newark (7)
Morrison, Frederick H., 61 High st., Newton (19)
Morrow, Jos. R., Bergen Pines, Oradell (2)
Moschkowitz, Hermann, 737 High st., Newark (7)

Mosher, Henry L., 325 Valley Br'k av., Lyndhurst(2)
Moss, Mary C., 5 Mountain av., Maplewood (7)
Mott, Joseph E., 426 Park av., Paterson (16)
Motzenbecker, Peter F., 680 High st., Newark (7)
Motzenbecker, Wm. J., 16 Milford av., Newark (9)
Mount, Elmer M., 74 Sherman pl., Jersey City (7)
Mount, Walter B., 21 Plymouth st., Montclair (7)
Mountford, Wm. E., 215 N. Warren st., Trenton (11)
Muccia, John J., 7 Tonnele av., Jersey City (9)
Mueller, George H., 102 Summit av., Jersey City (9)
Muldoon, Edward J., 200 Third st., Florence (3)
Muller, Frederick L., 413 Third st., Carlstadt (2)
Muller, Joseph H., 867 S. 13th st., Newark (7)
Mulligan, Luke A., 230 Central av., Leonia (2)
Mullin, Eugene F., 505 Sanford av., Newark (7)
Mullin, Raymond J., 76 Shanley av., Newark (7)
Mullins, Roy L., 305 Harrison st., Frenchtown (10)
Mulvihill, Wm. J., 275 Hudson Blvd., Bayonne (9)
Munger, Ray T., 727 Watchung av., Plainfield (2)
Munro, Charles A., Marlton (3)
Munro, Jeannette, 2 Queenston pl., Princeton (11)
Murn, Charles J., 48 Smith st., Paterson (16)
Murphy, Albert T., 1108 Anna st., Elizabeth (20)
Murphy, Charles M., 21 Main st., Farmingdale (13)
Murphy, Herschel S., 320 Chestnut st., Roselle (20)
Murphy, James A., 312 Bellevue av., Trenton (11)
Murphy, James M., 2757 Boulevard, Jersey City (9)
Murphy, Leo J., 374 West st., Union City (9)
Murphy, Patrick H. W., 27 Jefferson av., Jer.City(9)
Murray, Edwin N., 558 Newton av., Camden (4)
Murray, Harrold A., 624 Mt. Prospect av., New'k(7)
Murray, Joseph A., 765 Ave. C, Bayonne (9)
Murray, Norman L., 129 Summit av., Summit (20)
Murray, Robert A., 27 E. Greenwood av., Oaklyn(4)
Murto, Thomas V., 532 W. State st., Trenton (11)
Musetto, Carmelo A., 135 Cornelia st., Boonton (14)
Mustermann, Otto H., 303 48th st., Union City (9)
Muta, Samuel A., 47 Park av., West Orange (7)
Mutchler, H. Raymond, 153E.Blackwell st.,Dover(14)
Mutchler, Julia C., 153 E. Blackwell st., Dover (14)
Muttart, George W., 702 Ocean av., Jersey City (9)
Mutter, Alfred A., 75 Beech st., Arlington (9)
Myatt, Leslie E., 98 N. Pearl st., Bridgeton (6)
Myers, Norman V., 41 Magnolia av., Tenaflly (2)

ASSOCIATE MEMBERS

Maggio, Nicholas A., 130 Fleming av., Newark (7)
Maisel, Irving, Sav. Ordnance Depot,Savanna,Ill.(7)
Masciocchi, Thomas A., 316 Park av., Orange (7)
McLaughlin, Thomas F., 597 Main st., Metuchen(12)
Moore, James A., 99 So. Mountain av., Montclair(7)

Miller, George M., 94 Washington av., Carteret (12)
Miller, Reginald C., 1420 Greenwood av.,Trenton(11)
Miller, S. David, 161 New st., New Brunswick (12)
Mitchell, Walter L., Jr., 195 Roseville av.,Newark(7)

N

ACTIVE MEMBERS

Nacca, Carl A., 86 N. Essex av., Orange (7)
Nadel, Chas. I., 1186 Clinton av., Irvington (7)
Nafash, Shafeek, 301 Palisade av., Union City (9)
Nafey, Herbert W., 51 Livingston av.,N'wBrns.(12)
Nagler, Benedict, 25 Clinton pl., Newark (7)
Naidorff, Saul A., 404 W. 7th st., Plainfield (20)
Nalitt, David I., 28 W. 33rd st., Bayonne (9)
Nappi, Pasquale E., 250 Mt. Prospect av.,Newark(7)
Nash, Alexander E., 30 Forest av., Verona (7)
Nash, Herman S., 865 S. 11th st., Newark (7)
Nash, William G., 20 Clinton st., Newark (7)
Nataro, Joseph, 172 Littleton av., Newark (7)
Naulty, Chas. W., Jr., 403 High st., P'th Amboy(12)
Navazio, Attilio, 185 Speedwell av., Morristown (14)
Nayfield, Ronald C., 974 S. Broad st., Trenton (11)

Neal, Chas. B., Pine & 3rd sts., Millville (6)
Neary, Edward R., 1 W. Harriet av.,PalisadesP'k(2)
Neer, William, 245 Broadway, Paterson (16)
Neiderhoffer, Sydney L., 469 B'way, L'g Branch(13)
Nelson, Harry, 36 Lupton av., Woodbury (8)
Nemirow, Martin, 234 Lexington av., Passaic (16)
Nemzek, Wm. P. B., 141 Ridge rd., N. Arlington (7)
Nesbitt, Elizabeth, No.Jer.Tr'n'gSch'l,LittleFalls(16)
Netz, Lester W., 414 Main st., Hackensack (2)
Neville, Robert J., 547 Main st., Hackensack (2)
Nevius, William B., 610 Park av., E. Orange (7)
Newcomb, Marcus W., Browns Mills (3)
Newman, Abraham J., 132 Manhattan av.,Jer.C'y(9)
Newman, Grace T., 339 Grove st., Montclair (7)
Newman, Julius, 31 Lincoln Park, Newark (7)

- Newmeyer, Joseph, 739 Chestnut st., Delanco (3)
 Ney, J. Marshall, 671 Broad st., Newark (7)
 Nichols, Frank I., 52 Euclid av., Hackensack (2)
 Nichols, Stanley H., 517 B'way, Long Branch (13)
 Nicholson, Frank P., 895 Summit av., Jersey City (9)
 Nickman, E. Harrison, 4702 Atlantic av., Atl.C'y (1)
 Nicol, Lorenz C., 360 Larch av., Bogota (2)
 Nicola, Toufick, 96 Gates av., Montclair (7)
 Nicoll, George L., 25 MacDavitt pl., Dover (14)
 Nieman, Solomon Z., 136 Livingston av., N'w Brns. (12)
 Niemtzow, Frank, 55 E. Main st., Freehold (13)
 Nitshe, George A., Jr., 100 S. Main st., Elmer (6)
 Nittoli, Rocco M., 660 E. Jersey st., Elizabeth (20)
 Nobile, James J., 913 Hudson st., Hoboken (9)
 Noll, Louis, 1383 Clinton av., Irvington (7)
 Nonziato, Frank A., 50 Centre st., Trenton (11)
 Normand, Alphonse F., 113 Market st., P'th Amboy (12)
 Norris, Henry M., 21 Sterling dr., S. Orange (7)
 North, Harry R., 160 W. State st., Trenton (11)
 Norton, James F., 58 Kensington av., Jersey City (9)
 Norval, William A., 419 Main st., Paterson (16)
 Norwich, Louis E., 355 Ave. C, Bayonne (9)
 Norwood, Wm. D., 164 1st st., Carneys Point (17)
 Notkin, Meyer, 559 Broadway, Paterson (16)
 Noto, Philip, 158 Washington pl., Passaic (16)
 Novello, Joseph A., 641 Second av., Elizabeth (20)
 Nuse, Edward F., 550½ Jersey av., Jersey City (9)
 Nussbaum, Harvey E., 89 Ferry st., Newark (7)
 Nussbaum, Joseph, 321 Elmora av., Elizabeth (20)
 Nye, Howard H., 174 Carroll st., Paterson (16)
 Nyiri, William A., 863 So. 12th st., Newark (7)
 Nyvall, Pierre J., Barnaget (15)

ASSOCIATE MEMBER

- Neiman, Watson E., 618 Forman av., Pt. Pleasant (15) Nelson, Axel R., 35 William st., Fords (12)

O

ACTIVE MEMBERS

- Oberlander, Gertrude, 135 Johnson av., Newark (7)
 Obert, J. Edwin, Main st., New Egypt (15)
 Obester, Gabriel E., 640 N. Broad st., Elizabeth (20)
 O'Brian, Dennis M., 154 Lexington av., Passaic (16)
 O'Brien, Edwin J., Jr., 507 Park av., Plainfield (20)
 O'Brien, Paul, 196 Main st., E. Rutherford (2)
 Ockene, Abraham, 2415 Palisade av., Union City (9)
 O'Connell, James J., 116 Liv'gston av., N'w Brns. (12)
 O'Connor, Bernard A., 47 Central av., Newark (7)
 O'Connor, Dennis F., 671 Broad st., Newark (7)
 O'Connor, John J., 434 New York av., Union City (9)
 O'Connor, Michael J., 98 Shanley av., Newark (7)
 O'Connor, Paul A., 157 Roseville av., Newark (7)
 O'Crowley, Clarence R., 31 Lincoln Park, Newark (7)
 Oderr, Charles, 116 S. Euclid av., Westfield (20)
 Offenkrantz, Frederick M., 72 Hansbury av., New'k (7)
 O'Gorman, Michael W., 895 Bergen av., Jer. City (9)
 O'Grady, Benson J., 931 Washington st., Hoboken (9)
 O'Grady, Michael J., 228 Franklin av., Nutley (7)
 O'Hanlon, George, Medical Center, Jersey City (9)
 Okin, Irving, 165 Passaic av., Passaic (16)
 Oleynick, Simeon A., 31 Lincoln Park, Newark (7)
 Olini, Joseph J., 30 W. Market st., Newark (7)
 Olpp, Archibald E., 1516 Bergenline av., Union C'y (9)
 Olpp, John L., 100 E. Palisade av., Englewood (2)
 O'Mara, John A., 314 St. Clair av., Spring Lake (13)
 O'Neill, Charles L., 11 N. 7th st., Newark (7)
 O'Neill, John H., 270 Montgomery st., Jersey City (9)
 O'Neill, Joseph F., 41 E. Broad st., Hopewell (11)
 Opacity, Ernest A., 247 Madison av., Newark (7)
 Opdyke, Gordon M., 52 Claremont av., Verona (7)
 Openchowski, Mieczyslaw, 83 Johnson av., New'k (7)
 Opfermann, John L., 167 Bay av., Highlands (13)
 Oppen, Philip, 715 Broadway, Paterson (16)
 Oram, Joseph H., 495 Broadway, Paterson (16)
 Oren, Hyman, Park av., Park Ridge (2)
 Orloff, Samuel, 149 Lyons av., Newark (7)
 Ornaf, I. Edward, 1145 Thurman st., Camden (4)
 O'Rourke, James J., 871 Stuyvesant av., Trenton (11)
 Orris, Harold J., 1463 Maple av., Hillside (7)
 Ortolano, James J., 159 First st., Hoboken (9)
 Orton, Foster, 196 Elm av., Rahway (20)
 Orton, George L., 196 Elm av., Rahway (20)
 Orton, Henry B., 224 Delavan av., Newark (7)
 Osborn, A. Downey, 519 Sixth av., Belmar (13)
 O'Shea, John J., 2200 Palisade av., Weehawken (9)
 Osher, Morris M., 157 North av., Fanwood (20)
 Oshrin, Henry, 750 Park av., West New York (9)
 Osmun, Milton M., 611 Broadway, Camden (4)
 Osterreicher, Desider, 427 Bergen av., Jersey City (9)
 Ostrowski, Sigismund J., 265 Broad st., Bloomf'd (7)
 O'Sullivan, John R., 11 Quincy av., Arlington (9)
 Owen, Logan S., 938 Hudson st., Hoboken (9)
 Owen, Philip, 1273 Stuyvesant av., Union (20)

ASSOCIATE MEMBERS

- Ogden, Andrew E., 1829 Greenwood av., Trenton (11) Oransky, Marvin, 534 S. 11th st., Newark (7)
 Ogden, Michael A., Passaic Gen. Hosp., Passaic (16) Ort, Franz J., 160 N. Day st., Orange (7)

P

ACTIVE MEMBERS

- Pacicco, Michele, 376 Monmouth st., Jersey City (9)
 Padden, Aloysius F., 408 Main st., Hackensack (2)
 Paddock, Royce, 965 Broad st., Newark (7)
 Padney, Edward V., 452 Jersey av., Jersey City (9)
 Pagano, Peter, 45 N. Broad st., Ridgewood (2)
 Pagliughi, John J., 401 18th st., Union City (9)
 Pal, Darbari R., 32 Clark st., Paterson (16)
 Palma, Nicholas, 116 17th av., Paterson (16)
 Palmer, Francis R., 220 Lexington av., Passaic (16)
 Palmer, Gideon H., 28 Winans st., East Orange (7)
 Palmer, Henry S., 275 Mulberry st., Newark (7)
 Panigrosso, Laurie R., 455 Lawrie st., P'th Amboy (12)
 Panitch, William, 90 Baldwin av., Newark (7)
 Pannullo, John N. P., 266 Van Buren st., Newark (7)

- Pansy, Abraham A., 12 Jackson st., So. River (12)
 Pantaleone, Joseph, 504 Hamilton av., Trenton (11)
 Parell George C., 275 S. 7th st., Newark (7)
 Parent, Sol, 51 Baldwin av., Newark (7)
 Parisi, Anthony, 296 S. Orange av., Newark (7)
 Park, M. Benjamin, 360 Park av., Paterson (16)
 Parker, Horace N., 72 N. Clinton av., Trenton (11)
 Parker, James W., 175 Shrewsbury av., Red B'k(13)
 Parker, John E., 144 Harrison st., East Orange (7)
 Parkes, Morey, 33 Park av., Caldwell (7)
 Parry, Allen A., 46 Green Village rd., Madison (14)
 Parry, Antoinette R., 46 GreenVillage rd.,Madison(14)
 Parry, Oliver K., 601 Bangs av., Asbury Park (13)
 Parsonnet, Aaron E., 3 Madison av., Newark (7)
 Parsonnet, Eugene V., 31 Lincoln Park, Newark (7)
 Pascall, Thomas M., 197 Lincoln av., Newark (7)
 Patella, Fulvio, 324 Broadway, Paterson (16)
 Pattenden, Franklin J., 300 2nd av., Asbury P'k(13)
 Patterson, Isaac N., 230 Broadway, Westville (8)
 Patti, Frank A., 241 Broad av., Leonia (2)
 Patton, Paul B., Philipsburg (21)
 Pattysen, R. A., 50Nameaug st.,NewLondon,Conn.(7)
 Paul, George A., 788 Lyons av., Irvington (7)
 Paul, H. Carl, 30 Westville av., Caldwell (7)
 Paulson, Arch M., 160 E. 7th st., Plainfield (20)
 Pavia, John R., 48 Mountainview av., E. Orange (7)
 Payne, Guy, Essex Co. Hosp., Cedar Grove (7)
 Payne, Guy, Jr., 56 S. Prospect st., Verona (7)
 Payne, Joseph, 223 Godwin av., Midland Park (2)
 Peacock, Arthur B., 39 W. Main st., Columbus (3)
 Pearl, Sydney S., 545 Rahway av., Elizabeth (20)
 Pearlstein, Frank, 325 60th st., W. New York (9)
 Pearson, J. Gerald, 819 Washington st., Hoboken (9)
 Pearson, Theodore A., Whitehouse (10)
 Pecora, Carmine L., AtlanticCityBlvd.,Beachw'd(15)
 Pedevick, Joseph R., 232 Highl'd av.,PalisadesP'k(2)
 Pedrick, William W., 11 West st., Glassboro (8)
 Peer, Lyndon A., 965 Broad st., Newark (7)
 Pegau, Paul M., 246 Briar Hill lane, Woodbury (8)
 Pellarin, John D., 493 New York av., Union City (9)
 Pellet, Thomas L., Hamburg (19)
 Pellicane, Anthony J., 183 Liv'gst'n av.,N'wBrns.(12)
 Pechansky, Samuel J., 847 Ave. C, Bayonne (9)
 Pendexter, Sidney E., 11 S.Arlingt'n av.,E.Orange(7)
 Pennington, Alfred W., 398 N. Maple av., E. Or.(7)
 Pennington, John, 101 S. Indiana av., AtlanticC'y(1)
 Pentecost, Salvador D., 1424 Springf'd av.,Irv'gt'n(7)
 Pentel, Louis S., 307 60th st., West New York (9)
 Perham, Bertram S., 199 Lorraine av., Up.M'tel'r(7)
 Perham, Roy G., 248 Boulevard, Hasbr'k Hgts. (2)
 Perkel, Louis L., 2801 Hudson Blvd., Jersey City (9)
 Perlberg, Harry J., 921 Bergen av., Jersey City (9)
 Perneti, Anthony M., 320 Broadway, Paterson (16)
 Perrine, Cornelius C., 668 River rd., FairHaven(13)
 Perrone, Anthony J., 456 Roseville av., Newark (7)
 Perrone, Arthur F., 415 60th st., West New York(9)
 Perrotta, Anthony J., 94 Maple av., Red Bank (13)
 Perry, Frank L., 39 East av., Woodstown (17)
 Pessel, Johannes F., 224 W. State st., Trenton (11)
 Peters, Edgar A. P., 394 Bergen av., Jersey City(9)
 Peters, Richard C., 963 Park av., Plainfie'd (20)
 Peterson, Charles A., 921 Wash'gton st.,Hoboken(9)
 Peterson, Walter R., 312 W. State st., Trenton (11)
 Petry, William, 109 Treacy av., Newark (7)
 Pettit, Harry H., 138 Frank'in av., Ridgewood (2)
 Pettit, Herschel, 807 Wesley av., Ocean City (5)
 Pflug, Ferdinand J., 732 Hudson st., Hoboken (9)
 Phelan, Walter F., 124 Chilton st., Elizabeth (20)
 Phelps, James E., 203 Park av., Paterson (16)
 Phillips, Algernon A., 212 W. Market st., Newark(7)
 Phillips, Claude B., 891 Haddon av., Co'llingswood(4)
 Phillips, Walter, 109 E. Palisade av., Englewood (2)
 Pieper, Howard C., 426 Bath av., Long Branch (13)
 Pierson, Carl L., 395 W. State st., Trenton (11)
 Pierson, Joseph R., 10 E. Broad st., Hopewell (11)
 Pietri, Raoul, 501 Grand av., Asbury Park (13)
 Pigott, Albert W., N. J. State Village, Skillman (18)
 Pike, Charles E., 411 Newton av., Oakdyn (4)
 Pilch, Arthur G., 1 Willard av., Bloomfield (7)
 Pilkington, Albert, 117 S. Virginia av.,AtlanticC'y(1)
 Piller, Jacob, 213 Broadway, Paterson (16)
 Pilloni, Louis, 91 Beach st., Bloomfield (7)
 Piltz, George F., 153 25th st., Guttenberg (9)
 Pinckney, Frank H., 186 South st., Morristown (14)
 Pindar, Frederick S., 960 Park av., Woodcliff (9)
 Pindar, William A., 7523 Broadway, N. Bergen (9)
 Pinerman, Robert B., 308 W. State st., Trenton(11)
 Pinkerton, Wm. A., 854 Ave. C, Bayonne (9)
 Pinks, David K., 921 Bergen av., Jersey City (9)
 Pino, Anthony, 196 Irving av., Bridgeton (6)
 Pinsky, Harry A., 944 S. 5th st., Camden (4)
 Pinto, Joseph A., 50 N. 11th st., Newark (7)
 Piskorski, Abdon V., 604 Jersey av., Jersey City (9)
 Pitkin, George P., 4 S. Washington av.,Bergen'd(2)
 Pitman, Mason W. H., 17 W. Cliff st., Somerville(18)
 Pittman, Allen R., N. J. State Hosp., Trenton (11)
 Pizzi, Francis W., 205 Park av., Orange (7)
 Pizzi, Mario V., 205 Park av., Orange (7)
 Placa, James A., 112 Prospect st., Ridgewood (2)
 Plant, James S., 502 High st., Newark (7)
 Plante, Amos A., 437 Ridgewood rd., Maplewood (7)
 Platt, Edward V., 221 8th av., Haddon Heights (4)
 Platt, Thos. H., 307 N. Washington av.,Dunellen(12)
 Plavin, Nathan J., 8010 Hudson Blvd., N. Bergen (9)
 Plinke, Fritz W., 159 Lexington av., Passaic (16)
 Plume, Clarence A., Main st., Succasunna (14)
 Podell, A. Alfred, 51 E. Front st., Red Bank (13)
 Pogoloff, Samuel H., 68 N. First av., Manville (18)
 Pois, John, 52 Pillot pl., West Orange (7)
 Poland, George A., 206 E. Verona av.,Pl'santville(1)
 Poleshuck, Rubin, 100 Hollywood av., Hillside (20)
 Policastro, Nelson C., 378 Union st., Hackensack(2)
 Polizzotti, Joseph L., 193 Park av., Paterson (16)
 Polk, Charles C., 114 E. 7th av., Roselle (20)
 Pollack, Louis, 1008 E. Jersey st., Elizabeth (20)
 Pollak, Berthold S., 100 Clifton pl., Jersey City (9)
 Poller, Frederick K., 681 Stuyvesant av.,Irvingt'n(7)
 Pollis, Nicholas L., 642 High st., Newark (7)
 Polow, Benjamin, 24 Johnson av., Newark (7)
 Polowe, David, 555 E. 27th st., Paterson (16)
 Pomeranz, Raphael, 31 Lincoln Park, Newark (7)
 Pons, Carlos A., 501 Grand av., Asbury Park (13)
 Pontery, Herbert B., 89 Bowers st., Jersey City (9)
 Potter, Benjamin P., 90 Clifton pl., Jersey City (9)
 Potter, Charles W., Belvidere av., Washington (21)
 Potter, Ellen C., 301 W. State st., Trenton (11)
 Potter, Raymond T., 144 Harrison st., E. Orange (7)
 Pottinger, Wm. E., 6 Altamont court,Morrist'n(14)
 Povalski, Alexander W. T., 1925 Blvd., JerseyCity(9)
 Powis, Ethel M., 198 W. State st., Trenton (11)
 Poyas, Morton L., 306 W. State st., Trenton (11)
 Prager, Bert A., 251 Main st., Chatham (14)
 Prall, Henry E., 755 Anderson av., Cliffside Park(2)
 Prather, Charles G., 260 Westwood av.,Westwood(2)
 Prather, John W., 155 N. Wash'gton av.,Dumont(2)
 Pratt, Arthur G., 516 Cooper st., Camden (4)
 Pratt, William H., 516 Cooper st., Camden (4)
 Pregnall, James P., 501 Grand av., Asbury Park (13)
 Prestifilippo, Silvestro, 105 Glenridge av., Mtch. (7)
 Preston, Perry B., 12 Palm st., Newark (7)
 Price, Charles W., Essex Co. Hosp., Cedar Grove (7)
 Price, Henry S. Jr., 3005 Kearsage av., Camden (4)
 Price, Nathaniel G., 24 Johnson av., Newark (7)
 Prigger, Edward R., 39 W. Main st., Pennsgrove(17)
 Prince, Robert A., 567 Broadway, Paterson (16)
 Prince, Samuel, 516 34th st., Union City (9)
 Principato, Roberto, 402 Walnut st., Camden (4)
 Probst, Everett W., 176 Carmita av., Rutherford(7)
 Proctor, Francis E., 332 W. State st., Trenton (11)
 Proctor, Jesse E., 15 N. 13th st., Newark (7)

- Protzman, Thomas B., 39 Park pl., Englewood (2)
 Prout, Thomas P., 19 Prospect st., Summit (20)
 Prout, Wm. B., 88 W. Forrest av., W. Englew'd (2)
 Provisor, Benjamin, 141 Lexington av., Passaic (16)
 Pudney, Wm. K., 31 Trinity pl., Montclair (7)
 Pullen, Guy F., 111 Leonia av., Leonia (2)
 Purcell, Ernest F., 800 Stuyvesant av., Trenton (11)
 Purdy, Charles H., 35 Highland av., Jersey City (9)
 Pyle, Louis A., 89 Fairview av., Jersey City (9)
 Pyle, Wallace, 15 Exchange pl., Jersey City (9)

ASSOCIATE MEMBER

Pellicciari, Donald, 29 S. Munn av., East Orange (7)

Q

ACTIVE MEMBERS

- Quad, Clifford W., 52 Northfield av., West Orange (7)
 Quigley, Frederic J., 543 45th st., Union City (9)
 Quinby, William O., 14 James st., Newark (7)
 Quinn, John J., 921 Bergen av., Jersey City (9)
 Quinn, Norman J., 3303 Pacific av., Atlantic City (1)
 Quirk, Martin A., 90 W. Front st., Red Bank (13)

ASSOCIATE MEMBER

Quinn, Edward D., 323 Belleville av., Bloomfield (7)

R

ACTIVE MEMBERS

- Raab, Michael, 226 President st., Passaic (16)
 Rachlin, Harry T., 396 Union av., Irvington (7)
 Rader-Hoheb, Katherine A., 5 Lincoln av., Rthrfd. (2)
 Radest, Louis J., 347 Broadway, Paterson (16)
 Rados, Andrew, 31 Lincoln Park, Newark (7)
 Raffetto, Joseph F., 550 Cookman av., Asbury Pk (13)
 Ragany, Joseph, 966 S. Broad st., Trenton (11)
 Ragione, Mario D., 277 Clifton av., Newark (7)
 Rainey, Willard G., 34 Bayard lane, Princeton (11)
 Ram, Nathan H., 34 Park av., Caldwell (7)
 Rampona, Joseph M., 272 Nassau st., Princeton (11)
 Ramsey, F. Muriel, 310 E. Pine st., Millville (6)
 Randazzo, Anton P., 82 Prospect st., Passaic (16)
 Ranson, Briscoe B., Jr., 144 Harrison st., E. Orange (7)
 Rapp, Robert F., 932 Haddon av., Collingswood (4)
 Rathgeber, Chas. F., 18 William st., E. Orange (7)
 Rauschenbach, Paul E., 225 Broadway, Paterson (16)
 Ravitz, Samuel F., 1082 Broad st., Newark (7)
 Rawitz, Sidney B., 42 Chancellor av., Newark (7)
 Read, Donald B., 105 Hudson st., Jersey City (9)
 Read, Hilton S., 5407 Atlantic av., Ventnor (1)
 Read, Jessie D., 519 Lenox av., Westfield (2)
 Read, Wm. T., Jr., 429 Cooper st., Camden (4)
 Reading, H. Eugene, 535 E. 29th st., Paterson (16)
 Reale, Frank P., Brooks Blvd., Manville (18)
 Reale, Nicholas P., Brooks Blvd., Manville (18)
 Reason, John J., 612 Roosevelt av., Carteret (12)
 Reeve-Allen, Jane, 254 Midland av., Montclair (7)
 Reeves, Ernest, 195 Lexington av., Passaic (16)
 Reeves, J. Franklin, 55 East av., Bridgton (6)
 Reich, Abraham L., 83 Lyons av., Newark (7)
 Reich, Henry, 31 Lincoln Park, Newark (7)
 Reich, Jerome J., 1410 Maple av., Hillside (20)
 Reich, Mortimer, 31 Lincoln Park, Newark (7)
 Reich, Samuel B., 286 Union st., Hackensack (2)
 Reid, Erwin W., 125 Marsellus pl., Garfield (2)
 Reilly, Christopher J., 331 13th av., Newark (7)
 Reilly, David F., Bergen Pines, Oradell (2)
 Reilly, John V., 520 Sanford av., Newark (7)
 Reilly, Thomas F., 127 Union av., Clifton (16)
 Reiner, David N., 265 Lexington av., Passaic (16)
 Reiner, Jacob, 811 N. Broad st., Elizabeth (20)
 Reingold, Alexander, 221 Garden st., Hoboken (9)
 Reinhardt, Warren I., 276 Springdale av., E. Orange (7)
 Reinhold, Herb't E., 441 W. Eng'l'w'd av., W. Eng'w'd (2)
 Reinhorn, Abraham J., 302 Broadway, Paterson (16)
 Reisinger, Paul B., 369 W. State st., Trenton (11)
 Reissman, Erwin, 31 Lincoln Park, Newark (7)
 Reiter, Walter A., 50 DeForest av., Summit (20)
 Reitman, Norman, 73 Livingston av., N'w Brnswk. (12)
 Reitnauer, John S., 518 44th st., Union City (9)
 Reitter, George S., 191 Halsted st., E. Orange (7)
 Relyea, George M., 129 Summit av., Summit (20)
 Remer, Daniel F., 417 High st., Mt. Holly (3)
 Renner, Clara C., N. J. State Village, Skillman (18)
 Renzulli, Francesco, 228 S. 7th st., Newark (7)
 RePass, Paul E., 85 Harrison st., E. Orange (7)
 Resch, Henry U., 27 Park pl., Bloomfield (7)
 Restaino, Charles F., 1 Garside av., Newark (7)
 Rettig, Isidor L., 36 Milford av., Newark (7)
 Reyner, Daniel C., 2703 Pacific av., Atlantic City (1)
 Reynolds, Donald G., 64 W. Main st., Freehold (13)
 Reynolds, George G., 64 W. Main st., Freehold (13)
 Reynolds, Harry C., 657 Main av., Passaic (16)
 Rhoads, S. Creadick, 104 Station av., Westville (8)
 Rhone, David S., 1202 Haddon av., Camden (4)
 Ribbans, Robert C., 63 Central av., Newark (7)
 Riccobono, Cosmo S., 334 Park av., Paterson (16)
 Rice, Franklin W., 184 South st., Morristown (14)
 Rich, Charles, 191 Littleton av., Newark (7)
 Rich, Wallace E., Essex Co. Hosp., Cedar Grove (7)
 Richards, Ernest W., 374 DeWolf pl., Hackensack (2)
 Richards, Paul S., 1 Main st., Butler (16)
 Richardson, Charles A., Main st., Closter (2)
 Richardson, Emma M., 581 Stevens st., Camden (4)
 Richardson, Marvin T., 14 E. Mt. Pl's'nt av., Liv'gst'n (7)
 Ricketts, Henry E., 31 Lincoln Park, Newark (7)
 Rieck, Allan, 507 S. Shore rd., Pleasantville (1)
 Rieck, Walter R., 379 Kearny av., Kearny (9)
 Riegert, Louis C., 475 White Horse Pk., Collingsw'd (4)
 Rieman, Aloysius P., 3566 Hudson Blvd., Jer. City (9)
 Riggins, Edwin N., 161 N. Arlington av., E. Orange (7)
 Riley, Philetus H., 26 Maple av., Morristown (14)
 Rineberg, Irving E., 94 Bayard st., New Brunswick (12)

- Ringe, Charles L., Jr., 786 Palisade av., Teaneck (2)
Ringewald, Robert H., 284 Broad av., Leonia (2)
Rinzler, Harry G., 127 Van Houten av., Passaic (16)
Ripley, Charles D., Curtis av., Pt. Pl'sant Beach (7)
Ripley, E. Warren, 56 Church st., Montclair (7)
Ripps, Maurice L., 410 Elmora av., Elizabeth (20)
Rise, Wilson S., 4502 Ventnor av., Atlantic City (1)
Ristine, Edwin R., 542 Cooper st., Camden (4)
Rita, James J., 235 S. Clinton av., Trenton (11)
Ritter, John J., 95 Ward st., Paterson (16)
Rizzolo, Edward M., 523 Union av., Belleville (7)
Robbin, Lewis, 18 Clinton pl., Newark (7)
Robbins, Charles M., 31 Lincoln Park, Newark (7)
Robbins, Eugene, 909 Broad st., Newark (7)
Robbins, Henry B., 144 Mercer st., Jersey City (9)
Robbins, Warren D., 202 Ocean av., Cape May (5)
Roberts, Allison H., 24 S. 9th st., Newark (7)
Roberts, Charles D., 71 Chestnut st., Englewood (2)
Roberts, David C., 158 S. Harrison st., E. Orange (7)
Roberts, Edgar W., 760 Palisade av., W. New Y'k (9)
Roberts, Frank A., 11 Park av., Caldwell (7)
Roberts, Joseph E., Jr., 403 Cooper st., Camden (4)
Roberts, William A., 11 Park av., Caldwell (7)
Robertson, Euston S., 22 Harding ter., Kearny (7)
Robertson, Grace M., 650 W. 7th st., Plainfield (20)
Robie, Theodore R., 144 Harrison st., E. Orange (7)
Robins, David, 24 Commerce st., Newark (7)
Robinson, Ernest A., 149 Atkins av., Asbury P'k (13)
Robinson, John T., 598 Watchung rd., B'd Brook (18)
Robinson, Lindsay E., 332 Park av., Newark (7)
Robinson, Louis H., 31 Lincoln Park, Newark (7)
Robinson, Silas E., Franklin Tnpk., Waldwick (2)
Robinson, Wm. A., 62 Main av., Ocean Grove (13)
Rocco, Frank, 729 Summer av., Newark (7)
Rodman, E. Warren, 503 Cooper st., Beverly (3)
Roer, William J., 21 Nesbit ter., Irvington (7)
Roemer, Jacob, 591 E. 27th st., Paterson (16)
Rogers, Dorothy M., 50 Cooper st., Woodbury (8)
Rogers, Harry, 144 Harrison st., East Orange (7)
Rogers, Harry L., 408 Main st., Riverton (3)
Rogers, Laurence H., Donnelly Mem. Hosp., Tr'nt'n (11)
Rogers, Richard M., 129 S. Munn av., E. Orange (7)
Rogers, Robert H., 49 Ninth av., Newark (7)
Roh, Robert F., 671 Broad st., Newark (7)
Romano, Anthony M., 332 Liberty av., Hillsdale (2)
Romano, Michael J., 468 Union av., Paterson (16)
Romano, Patrick J., 310 Central av., Orange (7)
Rona, Maurice, 10 Kirkpatrick st., New Brunswick (12)
Roop, Wm. O., 101 S. Indiana av., Atlantic City (1)
Rosamilia, Ralph E., 480 N. 7th st., Newark (7)
Rose, Abraham, 326 Broad st., Elizabeth (20)
Rose, Salvatore J., 242 Ivy court, Orange (7)
Rose, Wm. G., 182 Stockton st., Hightstown (11)
Roseman, Herman I., 25 Euclid pl., Montclair (7)
Rosen, Chas. D., 106 S. Harrison st., E. Orange (7)
Rosen, Sol, 214 N. 2nd st., Bridgeton (6)
Rosenbaum, Samuel X., 170 S. Clinton st., E. Orange (7)
Rosenberg, Alvin A., 22 High st., Morristown (14)
Rosenberg, Jacob, 692 Bergen av., Jersey City (9)
Rosenberg, L. Charles, 11 Murray st., Newark (7)
Rosenberg, Louis, 26 S. Stenton pl., Atlantic City (1)
Rosenberg, Max, 23 Wyndmoor av., Hillside (7)
Rosenblatt, Sidney, 1904 Pacific av., Atlantic City (1)
Rosenstein, Jacob L., 568 Bergen av., Jersey City (9)
Rosenstein, Saivel L., 2120 Springf'd av., Vauxhall (20)
Rosenthal, Abraham, 43 3rd av., Atlantic Highlands (13)
Rosenthal, Arnold J., 263 Clinton pl., Newark (7)
Rosenthal, Bernice D., E. Landis av., Vineland (6)
Rosenthal, Sydney, 95 Wilson av., Newark (7)
Rossell, Edward W., 801 Cooper st., Camden (4)
Rossi, Bartolomeo, 64 Lloyd pl., Belleville (7)
Rossi, Gene, 79 Talmadge av., Bound Brook (18)
Roth, Oswald H., 210 Littleton av., Newark (7)
Rothfuss, C. Howard, 574 Rahway av., W'dbridge (12)
Rothgesser, Jerome C., 786 Bergen st., Newark (7)
Rothhouse, Burnet, 31 Lincoln Park, Newark (7)
Rothman, Theodore, 494 Park av., Paterson (16)
Rothschild, Daniel L., 585 Elizabeth av., Newark (7)
Rothschild, Karl, 149 Liv'gston av., N'w Br'ns'w'k (12)
Rothseid, Abraham, 59 Avon av., Newark (7)
Rowan, Henry M., 224 W. State st., Trenton (11)
Rowland, James J., 321 Bay av., Water Witch (13)
Rowland, John H., 159 New st., N'w Bruns'w'k (12)
Rowohl, George O., 175 Washington av., Dumont (2)
Roy, Bert W., 25 Hamburg av., Sussex (19)
Roy, Joseph N., 95 17th av., Paterson (16)
RuBacky, Joseph F. A., 57 Passaic av., Passaic (16)
Rubba, Russell R., 21 Horton st., Hammonton (1)
Rube, Joseph A., 145 Prospect st., Ridgewood (2)
Rubens, Otto, 27 E. Blackwell st., Dover (14)
Rubenstein, Eli, 800 Ave. C, Bayonne (9)
Rubin, Abraham A., 77 S. Munn av., East Orange (7)
Rubin, Benjamin, 193 Main st., South River (12)
Rubin, David, 200 E. Jersey st., Elizabeth (20)
Rubin, Henry S., 11 High st., Morristown (14)
Rubin, Samuel, 45 E. Blackwell st., Dover (14)
Rubino, Nicholas M., 67 N. 4th st., Newark (7)
Rubinow, Saul M., 755 High st., Newark (7)
Ruch, Valentine, 115 W. Palisade av., Englewood (2)
Rucker, William C., 408 Main st., Hackensack (2)
Rudolph, John P., 108 W. Maple av., Merch'tville (4)
Ruffu, Henry L., 111 S. Boston av., Atlantic City (1)
Rullman, Walter A., 58 W. Front st., Red Bank (13)
Rundlett, Emilie V., 79 Prospect st., Jersey City (9)
Runnells, John E., Bonnie Burn Sana., Scotch PIs. (20)
Runyan, William J., 102 Broad st., Bloomfield (7)
Runyon, Laurance P., 80 Somerset st., N'w Brns. (12)
Ruocco, William B., 416 River st., Paterson (16)
Ruoff, Andrew C., 2414 New York av., Union City (9)
Russell, Chas. B., 119 Hamilton av., Paterson (16)
Russell, David L., 690 Bergen av., Jersey City (9)
Russo, Dominic T., 51 E. Somerset st., Raritan (18)
Russomanno, Raymond L., 227 Clifton av., Newark (7)
Ruttenberg, Louis, 18 Hopkins st., Woodbury (8)
Ruttenberg, Max, 303 Cooper st., Camden (4)
Ruvane, Joseph J., 38 Bentley av., Jersey City (9)
Ryley, Harold W., 1 Lincoln pl., E. Rutherford (2)
Ryman, Merlin T., 5 Dunbar st., Chatham (14)

ASSOCIATE MEMBERS

- Richlin, Padie, 316 George st., New Brunswick (12)
Rigeron, D. George, 160 Franklin st., Bloomfield (7)
Rommer, Jack J., 25 Ingraham pl., Newark (7)
Rosenthal, Oscar J., 666 Clinton av., Newark (7)
Ross, Peter W., 655 Main av., Passaic (16)
Rost, Adolf S., 357 Lincoln av., Orange (7)
Rozsa, Stephen, 811 S. 18th st., Newark (7)
Rubin, William, 419 George st., New Brunswick (12)

S

ACTIVE MEMBERS

- Sabarese, Theodore C., 122 Marsellus pl., Garfield (16)
 Sabini, Cecil F., 257 4th st., Hoboken (9)
 Sacco, Anthony G., 2200 New York av., Union City (9)
 Sacco, Gregory E., 191 Broad st., Red Bank (13)
 Sachs, Wilbert, 921 Bergen av., Jersey City (9)
 Sackin, Stanley, 1009 Hamilton av., Trenton (11)
 Sadoff, Joseph, 116 Elmora av., Elizabeth (20)
 Saffron, Morris H., 292 Paulson av., Passaic (16)
 Salasin, Samuel L., 511 Pacific av., Atlantic City (1)
 Salsberg, Ralph H., 23 Johnson av., Newark (7)
 Saltus, Lloyd S., 16 Elm st., Morristown (14)
 Salvati, Leo H., 275 Orchard st., Westfield (20)
 Salway, Benjamin, 321 S. Broad st., Trenton (11)
 Salzman, Nathan, 714 Broadway, Paterson (16)
 Samson, Norman D., 281 Kearny av., Kearny (7)
 Samter, Max, 4711 Westfield av., Camden (4)
 Samuels, S. Lawrence, 219 W. 7th st., Plainfield (20)
 Sandella, Jos. F., 138 Liv'gston av., N'w Brunswick (12)
 Sandler, Moses, 2013 Center av., Fort Lee (2)
 Sandler, Samuel A., 70 Anderson st., Hackensack (2)
 Sanfacon, Thomas A., 340 Park av., Paterson (16)
 Santangelo, Emil L., 349 Broadway, Paterson (16)
 Santangelo, Stephen, 461 Jersey av., Jersey City (9)
 Santor, G. Frank, 3176 Westfield av., Camden (4)
 Santora, Philip J., 361 Roseville av., Newark (7)
 Santosky, Benjamin B., 20 Tonnele av., Jersey City (9)
 Saradarian, Albert V., 2401 New York av., Union City (9)
 Sarajian, Aram M., 131 Market st., W. Englewood (2)
 Sarla, Michael, 55 Hudson st., Hackensack (2)
 Saslow, Benjamin I., 680 Clinton av., Newark (7)
 Sasso, Albert, 99 Parker st., Newark (7)
 Satulsky, Emanuel M., 652 Park av., Elizabeth (20)
 Saulsberry, Chas. E., 75 Livingston av., N'w Brns. (12)
 Saunders, Orris W., 1700 Broadway, Camden (4)
 Savel, Lewis E., 872 S. 16th st., Newark (7)
 Sawyer, Blackwell, 109 Wash'gton st., Toms River (15)
 Sax, Max T., 84 Grove st., Bloomfield (7)
 Sayre, William D., Box 202, Red Bank (13)
 Sbarra, Francesco C. N., 189 Roseville av., Newk (7)
 Scammell, Frank G., 40 S. Clinton av., Trenton (11)
 Scanlan, D. Ward, 15 S. Illinois av., Atlantic City (1)
 Scasserra, Benedict B., 163 Nassau st., Princeton (11)
 Schaafl, Royal A., 413 Mt. Prospect av., Newark (7)
 Schaefer, Eugene P., 12 Harrison pl., Irvington (7)
 Schafer, Marguerite A., 298 Dim'd Br. av., H'wth'rne (16)
 Schaffer, Barney, 252 Washington av., Belleville (7)
 Schall, Reuben E., 537 N. 7th st., Camden (4)
 Schapiro, Joseph, 3514 Palisade av., Union City (9)
 Schectman, Vera, 385 Osborne ter., Newark (7)
 Scheer, Eli, 7332 Hudson Blvd., North Bergen (9)
 Scheffler, Wilhelm A. H., 511 Cooper st., Camden (4)
 Scheffrin, Alex. E., 235 Lexington av., Passaic (16)
 Schellenger, Edward A. Y., 429 Cooper st., Camden (4)
 Scheller, George A., 701 Clinton av., Newark (7)
 Schenk, Joseph R., 1177 Park av., Plainfield (20)
 Schept, Samuel S., 523 37th st., Union City (9)
 Scher, Maurice A., 137 Lyons av., Newark (7)
 Schiffmann, Samuel, 107 Spruce st., Newark (7)
 Schildkraut, Jacob M., 170 W. State st., Trenton (11)
 Schiller, Edwin, 449 Westminster av., Elizabeth (20)
 Schiller, Nicholas, 29 Girard pl., Newark (7)
 Schiller, Rosa O., 449 Westminster av., Elizabeth (20)
 Schilling, Anthony B., 727 Jefferson av., Elizabeth (20)
 Schiro, S. Robert, 73 Main st., Lodi (2)
 Schisler, Milton M., 2nd & Church sts., Florence (3)
 Schlein, August, 707 Park av., Hoboken (9)
 Schlein, David, 812 N. Wood av., Linden (20)
 Schlichter, Chas. H., 556 N. Broad st., Elizabeth (20)
 Schlossbach, Theodore, 94 S. Main st., Ocean Gr. (13)
 Schmidt, Albert F., 81 Union av., Manasquan (13)
 Schmidt, Clifford M., 81 Main st., Newton (19)
 Schmidt, Walter W., 386 Palisade av., Cliffside Pk (2)
 Schneckendorf, Samuel J., 179 Harrison av., Jer. City (9)
 Schneider, Charles A., 694 Clinton av., Newark (7)
 Schneider, Clinton R., 125 N. Green st., Tuckerton (15)
 Schneider, Louis, 874 S. 13th st., Newark (7)
 Schneider, Louis A., 412 17th st., W. New York (9)
 Schotland, Clement E., 41 Leslie st., Newark (7)
 Schrack, Helen F., 216 N. 5th st., Camden (4)
 Schram, William S., N. J. State Village, Skillman (18)
 Schramm, Joseph A., 572 High st., Newark (7)
 Schreck, Harry, 192 Roseville av., Newark (7)
 Schretzmann, Rudolph C., 60 Don'l's'n av., R'th'rf'd (2)
 Schubert, Roy R., 466 Park av., Paterson (16)
 Schuchner, Wm. F., 550 1/2 Jersey av., Jersey City (9)
 Schuck, Traugott J., 58 9th st., Hoboken (9)
 Schulman, Abraham S., 4518 Blvd., Union City (9)
 Schulman, Robert, Aurora Health Inst., Morrist'n (14)
 Schulsinger, Samuel, 80 Clinton av., Newark (7)
 Schulte, Herbert A., 701 Clinton av., Newark (7)
 Schultz, Anna R., 207 Summer av., Newark (7)
 Schultz, Augustin M., 379 Union av., Paterson (16)
 Schurman, Francis H. C., 14 Smull av., Caldwell (7)
 Schwartz, Henry C., Raritan av., Atco (4)
 Schwartz, Jacob, 8-04 Fairlawn av., Fairlawn (16)
 Schwartz, Samuel H., 1044 Park av., Plainfield (20)
 Schwartz, William, 224 Lexington av., Passaic (16)
 Schwartzberg, Frederick I., 522 B'way, Paterson (16)
 Schwarz, Berthold T. D., 2787 Hudson Blvd., Jer. City (9)
 Schwarz, Henry J., 5560 Hudson Blvd., N. Bergen (9)
 Schwarzkopf, George C., 2901 Pacific av., Atl. City (1)
 Schweizer, Roman G., 36 Summit rd., Elizabeth (20)
 Schwinn, Chas., 7600 Winchester av., Margate City (1)
 Sciarillo, Louis F., 711 Garden st., Hoboken (9)
 Scielzo, Nicholas F., 369 Park av., Paterson (16)
 Scillieri, John, 811 E. 22nd st., Paterson (2)
 Sciorsci, Edward F., 609 Bloomfield st., Hoboken (9)
 Scott, Elmer A., Belle Mead Sana., Belle Mead (13)
 Scott, Frederick J., 1 Oak st., Franklin (19)
 Scott, Fred'k W., 103 Bayard st., New Brunswick (12)
 Scott, Harold R., 10 Speedwell av., Morristown (14)
 Scott, Parry M., 466 Cooper st., Beverly (3)
 Scott, R. Hunter, 205 Roseville av., Newark (7)
 Scott, Samuel G., 141 Bergen av., Jersey City (9)
 Scranton, Chas. W., 59 Wash'gton st., E. Orange (7)
 Scribner, Chas. H., Hamburg Tnpk., Preakness (16)
 Scudder, Frank D., 65 N. Fullerton av., Montclair (7)
 Scullion, Arthur A., 460 Anderson av., Cliffside Pk (2)
 Sealey, Henry J., 79 S. Washington av., Dumont (2)
 Seeler, Albert O., 33A Garden dr., Roselle (20)
 Seely, Roy B., 78 N. Clinton av., Trenton (11)
 Segard, Christian P., 204 Glenwood av., Leonia (2)
 Seidler, Victor B., 16 Plymouth st., Montclair (7)
 Seidman, Edwin A., 580 High st., Newark (7)
 Seidman, Joshua I., 31 Lincoln Park, Newark (7)
 Seifert, Edwin A., 415 Ridgew'd av., Glen Ridge (7)
 Seiler, Benjamin, 580 Palisade av., Cliffside Park (2)
 Seitzick-Robbins, Hannah E., 723 W. State st., Tr'n (11)
 Sekerak, Albert J., 984 S. Broad st., Trenton (11)
 Selinger, Samuel, 413 16th st., West New York (9)
 Sell, Frederick W., 167 W. Emerson av., Rahway (20)
 Sellitto, Anthony M., 268 Valley st., So. Orange (7)
 Selvaggi, Carlo, 82 Congress st., Newark (7)
 Sender, Fannie, 193 Main st., South River (12)
 Senerchia, Fred F., Jr., 604 W'stm's't'r av., Eliz. (20)
 Serri, William S., N. Main st., Mullica Hill (8)
 Seto, Stanford P. T., Black Horse Pk., Blackwood (4)
 Sewall, Millard F., 195 E. Commerce st., Bridgeton (6)
 Seward, Frederic H., 40 Gr'n Village rd., Madison (14)
 Seward, Wm. H., Orange Mem'l Hosp., Orange (7)
 Sewell, Stephen, 320 Passaic av., Spring Lake (13)
 Sexton, Edward V., 936 Queen Anne rd., Teaneck (2)

- Seybold, Arthur D., 1080 Rahway rd., Plainfield (20)
Seymour, Edward T., 55 Hillside av., Tenafly (2)
Seymour, George A., 253 Orchard st., Elizabeth (20)
Shack, David N., 712 Clinton av., Newark (7)
Shack, Maxwell H., 19 Lyons av., Newark (7)
Shafer, Albert H., 405 Cooper st., Camden (4)
Shafer, F. William, 634 Penn st., Camden (4)
Shaner, Ralph D., 94 Hillside av., Nutley (7)
Shangle, Milton A., 34 Prince st., Elizabeth (20)
Shanik, Wm., 600 4th av., Asbury Park (13)
Shannon, Jas. B., 66 S. Fullerton av., Montclair (7)
Shannon, Lardner M., 66 S. Fullerton av., Mtclair (7)
Shapiro, Charles S., Maple Shade (3)
Shapiro, Louis, 146 Broad st., Newark (7)
Shapiro, Louis G., 375 Broadway, Paterson (16)
Shapiro, Maurice, 750 Ave. C, Bayonne (9)
Shapiro, Nathaniel J., 212 Palisade av., Union City (9)
Shapiro, Saul J., 1215 Palisade av., Union City (9)
Sharp, Charles E., Main st., Port Norris (6)
Sharp, Reuben L., 719 Cooper st., Camden (4)
Shaul, Fred'k G., 10 Washington st., Bloomfield (7)
Shaul, John F., 10 Washington st., Bloomfield (7)
Shaw, Ernest B., 811 Collings av., W. Collingswood (4)
Shaw, John J., 127 Scheerer av., Newark (7)
Shayevitz, Abraham S., 102 Main st., So. River (12)
Sheaffer, Clinton P., 241 Kings H'way, E. Had'n'd (4)
Shear, Maurice M., 1158 E. State st., Trenton (11)
Shechtman, Abraham, 261 Main av., Passaic (16)
Sheehan, Daniel C., 535 Sanford av., Newark (7)
Sheeran, Vincent J., 269 Jewett av., Jersey City (9)
Sheets, Cecil C., 213 W. Broad st., Paulsboro (8)
Shemeley, William G., Jr., 7 Haddon av., Camden (4)
Shenfeld, Isaac, 4806 Atlantic av., Ventnor (1)
Sheppard, A. G., 309 Broad st., Elmer (6)
Sheppard, Frank R., 131 N. 3rd st., Millville (6)
Sheppard, Muse A., Penn & Broad sts., Elmer (6)
Sherk, A. Lincoln, 2647 Westfield av., Camden (4)
Sherman, A. Russell, 671 Broad st., Newark (7)
Sherman, Arthur E., 144 S. Harrison st., E. Orange (7)
Sherman, Benjamin, Aurora H'lth Inst., Morristown (14)
Sherman, Byron G., 52 Maple av., Morristown (14)
Sherman, Elbert S., 671 Broad st., Newark (7)
Sherman, Fuller G., 204 Delaware st., Woodbury (8)
Sherman, Samuel H., 81 Elmora av., Elizabeth (20)
Sherman, Wm. E., 88 Schureman st., N'w Br'n'sk (12)
Shili, Benjamin, 738 High st., Newark (7)
Shimer, A. Burton, 606 Pacific av., Atlantic City (1)
Shimer, Floyd A., 88 Lewis st., Phillipsburg (21)
Shipman, James S., 542 Cooper st., Camden (4)
Shippee, James N., 648 Ringwood av., Wanakee (16)
Shipp, Hammell P., 739 Chestnut st., Delanco (3)
Shirlock, Margaret E., Training School, Vineland (6)
Shirrefs, Russell A., 348 Elmora av., Elizabeth (20)
Shivers, Charles H. de T., 121 S. Illinois av., Atl. City (1)
Shlionsky, Herman, Essex Co. Hosp., Cedar Grove (7)
Shook, Benjamin E., 284 Bergen av., Jersey City (9)
Shope, Edward P., 511 Cooper st., Camden (4)
Shor, David M., 32 S. Munn av., E. Orange (7)
Shreehan, Hubert F., 620 Summer av., Newark (7)
Shull, Elliott C., 517 Cooper st., Camden (4)
Shull, John V., 84 Market st., Perth Amboy (12)
Shulman, Abraham, 528 E. 29th st., Paterson (16)
Shulman, Murray W., 913 S. 20th st., Newark (7)
Shulman, Nathan L., 538 45th st., Union City (9)
Sica, L. Samuel, 431 E. State st., Trenton (11)
Sickel, Emanuel M., 220 Madison av., Lakewood (15)
Siddall, John R., 404 Lippincott av., Riverton (3)
Sieber, Isaac G., 204 Merchant st., Audubon (4)
Siegel, Isadore, 121 Market st., Perth Amboy (12)
Siegel, Jack G., 38 Johnson av., Newark (7)
Siegel, Jacob W., 96 S. 10th st., Newark (7)
Siegel, Lester, 645 Bergen av., Jersey City (9)
Siegel, Sidney L., 227 N. Second st., Millville (6)
Siegler, Julius, 646 Bergen av., Jersey City (9)
Siemon, Theophilis R., 1005 Brunsw'k av., Tr'nt'n (11)
Silk, Charles I., 236 High st., Perth Amboy (12)
Sill, John B., 942 W. State st., Trenton (11)
Silver, E. Drew, 136 Stockton st., Hightstown (11)
Silver, Harry B., 190 Clinton av., Newark (7)
Silverman, Irving A., 260 Dayton av., Clifton (16)
Silverman, R. Louis, 3 Franklin st., Pennsgrove (17)
Silverstein, Benjamin J., 32 Hillside av., Newark (7)
Silverstein, Jacob M., 73 Main st., Millburn (7)
Silverstein, Max, 605 First av., Asbury Park (13)
Simeone, Peter A., 555 38th st., Union City (9)
Simkin, Abraham, 247 Broadway, Passaic (16)
Simmons, Albert V., 720 Prospect st., Maplew'd (7)
Simms, George F., 541 Page av., Lyndhurst (7)
Simon, Henry, 5 Vermont av., Newark (7)
Simon, Julius J., 174 Columbia av., Passaic (16)
Simon, Ludwig L., 201 Ferry st., Newark (7)
Simon, Morris L., 174 Washington pl., Passaic (16)
Simonson, Louis, 202 Osborne ter., Newark (7)
Sims, Richard V., Jr., 21 Morris av., Summit (20)
Sinexon, Henry L., 36 W. Broad st., Paulsboro (8)
Singer, Bella, 406 Elmora av., Elizabeth (20)
Singer, Max, 147 Johnson av., Newark (7)
Singer, Sina S., 3443 Boulevard, Jersey City (9)
Sinkinson, Chas. D., Jr., 1616 Pacific av., Atl. City (1)
Sinton, John Y., Imlaystown (11)
Sirota, E. Bernard, 220 W. Broad st., Paulsboro (8)
Sisson, Nelson W., 144 Harrison st., E. Orange (7)
Siveke, John, 106 Lexington av., Passaic (16)
Skvarla, John A., 17 Koster st., Wallington (2)
Skwinsky, Joseph, 170 Hawthorne av., Newark (7)
Slack, Clarence J., 230 W. State st., Trenton (11)
Slaff, Florence, 16 Grove st., Passaic (16)
Slavin, Paul, 31 Lincoln Park, Newark (7)
Sloan, Samuel L., 182 Belmont av., Paterson (16)
Slobodien, Benjamin F., 233 High st., Perth Amby (12)
Slocum, Harry B., 263 Bath av., Long Branch (13)
Sly, John L., 382 Springfield av., Summit (20)
Smaine, Enrique del C., 502 Summit av., Carlstadt (2)
Small, Louis, 23 Passaic av., Passaic (16)
Smalley, Mahlon C., Gladstone (18)
Smalley, Sara D., 530 Clifton av., Newark (7)
Smalzried, Elmer W., 69 Woodland av., E. Orange (7)
Smith, Alexander L., 2672 Boulevard, Jersey City (9)
Smith, Andrew M., 344 Phil'd'phia av., Egg H'rb'r (1)
Smith, Bertram H., 1000 Kings Hwy., Hadd'n Hts. (4)
Smith, Bryan A., 20 West plaza, Ridgewood (2)
Smith, Byron J., P. O. Box 754, Newark (7)
Smith, Carroll D., 320 Broadway, Paterson (16)
Smith, Christopher A., 295 Montgomery st., Bl'm'f'd (7)
Smith, Ellis L., Essex Co. Isolation Hosp., Belleville (7)
Smith, Elroy W., 39 Circle rd., Passaic (16)
Smith, Geo. H., 136 Evergreen pl., East Orange (7)
Smith, Harold W., 179 Lincoln av., Orange (7)
Smith, Henry G., Essex Co. Hosp., Cedar Grove (7)
Smith, Houghton C., 1063 S. Clinton av., Trenton (11)
Smith, Ivan B., Dayton (10)
Smith, J. Meredith, 212 Grand av., Hackettstown (21)
Smith, James D., 701 N. 6th st., Camden (4)
Smith, John A., 106 Main st., South River (12)
Smith, John V., 463 State st., Perth Amboy (12)
Smith, Joseph A., Roosevelt Hosp., Metuchen (12)
Smith, Joseph J., 325 13th av., Newark (7)
Smith, Leon A., 655 Main av., Passaic (16)
Smith, Leonard H., 32 Washington st., E. Orange (7)
Smith, Malcolm K., 22 Madison av., Morristown (14)
Smith, Marcia V., 821 Wesley av., Ocean City (7)
Smith, Marshall, 62 Bayard st., New Brunswick (12)
Smith, Meyer, 298 4th st., Jersey City (9)
Smith, Nehemiah E., 33½ Humphrey st., Englew'd (2)
Smith, Paul E., N. J. State Hospital, Trenton (11)
Smith, Percy L., Ridge rd., Dayton (12)
Smith, Thayer A., Forest dr., Short Hills (7)
Smith, W. Henley, 126 W. State st., Trenton (11)
Smith, Warren H., 91 Main st., Newton (19)
Smith, Wilbur A., 2 E. Clinton av., Oaklyn (4)

- Snagg, Wm. T., 719 Cooper st., Camden (4)
 Snavelly, Earl H., City Hospital, Newark (7)
 Snedecor, Spencer T., 50 Anderson st., Hack'n'sk (2)
 Snegireff, Leonid S., 49 Maple av., Trenton (11)
 Snyder, John E., 1023 Garden st., Hoboken (9)
 Snyder, W. Jay, 74 Columbia ter., Weehawken (9)
 Sobel, I. Jerome, 136 Broadway, Passaic (16)
 Sobin, Julius, 24 Waverly av., Newark (7)
 Sochacki, Alexander, 1478 Mt. Ephr'm av., Camden (4)
 Solk, Arthur G., 88 Clinton av., Newark (7)
 Solworth, Lee, 100 E. Palisade av., Englewood (2)
 Somers, Fred L., 144 Harrison st., E. Orange (7)
 Somers, Willard H., 157 Engle st., Englewood (2)
 Sommer, George N. J., 120 W. State st., Trenton (11)
 Sommer, Geo. N. J., Jr., 120 W. State st., Trenton (11)
 Sooy, L. Thomas, 202 W. Holly av., Pitman (8)
 Sorett, Joseph, 530 Central av., Newark (7)
 Sorock, Emil M., 1 Grumman av., Newark (7)
 Soschin, Samuel J., 31 Lincoln Park, Newark (7)
 Spalding, Henry J., 512 45th st., Union City (9)
 Spaldo, John L., N. J. State Village, Skillman (18)
 Spallone, Jos. C., 123 Mt. Prospect av., Newark (7)
 Spano, Frank, 320 47th st., Union City (9)
 Sparks, Paul R., 102 W. Broad st., Burlington (3)
 *Spath, George B., 722 Hudson st., Hoboken (9)
 Spath, William H., 722 Hudson st., Hoboken (9)
 Spence, Henry, 2540 Boulevard, Jersey City (9)
 Spencer, Alvan, 395 W. Blackwell st., Dover (14)
 Spencer, Ira T., 152 Main st., Woodbridge (12)
 Spencer, Jas. H., Jr., 23 Hospital rd., Franklin (19)
 Spickers, William, 6 Church st., Paterson (16)
 Spicola, Louis A., 343 Union st., Lodi (2)
 Spiegelglass, Abraham B., 417 Main st., H'ck'n'sk (2)
 Spillane, Timothy H., 379 S. Main st., Phillipsbg (21)
 Spinner, Samuel L., 190 Clinton av., Newark (7)
 Spirito, Michael W., 1071 Elizabeth av., Elizab'h (20)
 Spivack, David, 376 Elmora av., Elizabeth (20)
 Spohn, Eugene L., 511 Kearny av., Arlington (9)
 Spradley, Jeems B., N. J. State Hosp., Trenton (11)
 Sprague, Edward W., 86 Washington st., Newark (7)
 Sprague, Seth B., 301 York st., Jersey City (9)
 Spritzer, Theo. D., 102 S. Wahs'gton av., Dunell'n (12)
 Spurgeon, Chilton E., 19 Church st., Newton (19)
 Spurgeon, Dorsett L., 19 Church st., Newton (19)
 Staehle, Richard H., 34 Lyons av., Newark (7)
 Stage, Earl DeW., 11 James st., Morristown (14)
 Stahl, Alfred, 55 Lincoln Park, Newark (7)
 Stahl, Charles, 659 Sanford av., Newark (7)
 Stamps, G. Ruffin, 300 E. Verona av., Pt'santville (1)
 Stanton, Nathaniel B., 734 Park av., Plainfield (20)
 Stark, Harry L., 680 Hudson Blvd., Bayonne (9)
 Stark, Jacob, 645 Broadway, Paterson (16)
 Statman, Arthur J., 17 Leslie st., Newark (7)
 Staub, E. Milton, 531 E. Broad st., Westfield (20)
 Steel, John M., N. J. State Hosp., Trenton (11)
 Steel, William A., Beesley's Point (5)
 Steele, Stephen, 10 W. Gibbons st., Linden (20)
 Stefansin, Frank, 2020 West st., Union City (9)
 Steffens, Chas. T., 810 Madison av., Dunellen (12)
 Stein, Albert, 700 85th st., North Bergen (9)
 Stein, Emil, 607 Park av., Elizabeth (20)
 Stein, George H., 406 Elmora av., Elizabeth (20)
 Stein, Harold M., 227 W. Broadway, Paterson (16)
 Stein, Isadore, 817 N. Broad st., Elizabeth (20)
 Stein, Jacob M., 68 Columbia ter., Weehawken (9)
 Stein, Joseph M., 956 Newton av., Camden (4)
 Stein, Louis A., 226 W. State st., Trenton (11)
 Stein, Martin H., 60 Elmora av., Elizabeth (20)
 Stein, William, 177 Livingston av., NewBrunsw'k (12)
 Steinberg, Benjamin L., 543 Main st., Singac (16)
 Steinberg, Werner, 35 Gesner st., Linden (20)
 Steiner, Edwin, 31 Lincoln Park, Newark (7)
 Stephenson, Daniel H., 213 Haddon av., Haddonf'd (4)
 Stephenson, Gordon A., 145 Summit av., Summit (20)
 Stephenson, Ruth, N. J. Col. for Wom., N'wBrns. (12)
 Stern, Morris H., 709 Main av., Clifton (16)
 Stern, Samuel, 2815 Pacific av., Atlantic City (1)
 Steuart, David F. R., 11 De Barry pl., Summit (20)
 Stevens, Merton H., 58 S. Maple av., E. Orange (7)
 Stevenson, G. M., 129 Summit av., Summit (20)
 Stevenson, Geo. S., R.D. No. 1, Everett rd., RedB'k (13)
 Stewart, Irving J., 529 King's H'way, Swedesboro (8)
 Stewart, Robert G., 79 Midland av., Montclair (7)
 Stewart, Sloan G., N. Carolina & Pac. avs., Atl. City (1)
 Stewart, Walter B., 8 N. Tallahassee av., Atl. City (1)
 Stickles, Lloyd C., 49 Parkhurst st., Newark (7)
 Stiles, C. Campbell, 713 Park av., East Orange (7)
 Stillwell, Harry C., 51 W. Milton av., Rahway (20)
 Stimus, Howard G., 300 Kaighn av., Camden (4)
 Stinson, Richard, 641 E. 18th st., Paterson (16)
 Stockfisch, Robert H., 3637 Boulevard, Jersey C'y (9)
 Stokes, Anthony T., 819 First st., Secaucus (9)
 Stokes, Earle B., 144 Harrison st., East Orange (7)
 Stokes, James S., 85 Park av., Paterson (16)
 Stokes, Joseph, 220 E. Main st., Moorestown (3)
 Stokes, S. Emlen, 129 Chester av., Moorestown (3)
 Stoltz, Raymond R., 23 Passaic av., Passaic (16)
 Stone, Arthur L., 2838 Berkeley st., Camden (4)
 Stone, Frank P., Laurel rd., Laurel Springs (4)
 Stone, Robert G., N. J. State Hospital, Trenton (11)
 Storaci, Frank S., 715 Hamilton av., Trenton (11)
 Stout, J. Phillip, 165 Jewett av., Jersey City (9)
 Stouter, Francis L., 29 17th av., Paterson (16)
 Strack, Vincent J., 1072 S. Orange av., Newark (9)
 Strasser, Hans A., 226 N. Park st., E. Orange (7)
 Straub, Herbert H., 242 Springdale av., E. Orange (7)
 Straughn, Clinton C., 23 Monmouth st., RedBank (13)
 Straus, Max, 87 Harrison pl., Irvington (7)
 Strauss, Arthur, 130 Pavilion av., Long Branch (13)
 Strauss, Clifton J., 960 Sp'gf'd av., N'wPr'vid'nce (20)
 Strauss, Frederick, 845 S. 12th st., Newark (7)
 Strauss, Max, 190 Clinton av., Newark (7)
 Streen, Morris E., 908 Bergen st., Newark (7)
 Street, Daniel B., 27 Woodlawn av., Jersey City (9)
 Strelinger, Alexander, 650 N. Broad st., Elizab'h (20)
 Strom, Abraham, 410 W. 7th st., Plainfield (20)
 Stuart, J. Earle, 552 E. Second st., Plainfield (20)
 Stuart, William C., 518 Hudson st., Hoboken (9)
 Sturchio, Edoardo, 104 Ferry st., Newark (7)
 Sturchio, Eugenio, 178 Mt. Prospect av., Newark (7)
 Stybel, Joseph, 806 W. Front st., Plainfield (20)
 Subin, Harry, 1616 Pacific av., Atlantic City (1)
 Sucoff, Moses C., 158 Hamilton av., Passaic (16)
 Suffness, Gustave, 1081 E. Jersey st., Elizabeth (20)
 Sufrin, Emanuel, 119 N. 27th st., Camden (4)
 Sullivan, Chas. J., 57 Paterson st., NewBrunsw'k (12)
 Sullivan, James A., 46 Bentley av., Jersey City (9)
 Sullivan, Wm. M., Jr., 43 Passaic av., Passaic (16)
 Sullivan, William T., 35 DeWitt av., Belleville (7)
 Sulouff, S. Henry, 662 Newark av., Jersey City (9)
 Summerill, Garnett, 330 Cooper st., Camden (4)
 Summers, Alfred D., 180 Nassau st., Princeton (11)
 Summey, Thos. J., 800 Gulf View rd., Moorestown (3)
 Surgent, George W., 168 Clifton av., Clifton (16)
 Sussman, Harold, 541 44th st., Union City (9)
 Suter, Harry F., 49 W. Main st., Pennsgrove (17)
 Sutherland, William W., 400 B'dway, Paterson (16)
 Sutnick, Theodore B., 1018 S. Broad st., Trenton (11)
 Sutton, Harold L., 777 High st., Newark (7)
 Sutton, Joseph G., Essex Co. Hosp., Cedar Grove (7)
 Swain, Richard D., Jr., 211 Rosville av., Newark (7)
 Sweeney, Wm. J., 68 Clifton ter., Weehawken (9)
 Swern, Nathan, 399 W. State st., Trenton (11)
 Swertfefer, Herb't W., 22N. Greenw'd av., H'pew'lh (11)
 Swieczicki, Martin E., 317 Clem'nts Br. rd., Bar'gt'n (4)
 Swiney, Juliana C., 325 Ave. C, Bayonne (9)
 Swiney, Merrill A., 325 Ave. C, Bayonne (9)
 Symes, Earl R., 161 Kearny av., Kearny (7)
 Szerlip, Leopold, 31 Lincoln Park, Newark (7)
 Szold, Norman F., 701 Princeton av., Lakewood (15)
 Such, Nicholas, 159 Main st., South River (12)
 Szymanski, John J., 616 Main av., Passaic (16)

ASSOCIATE MEMBERS

- Salaky, William L., 387 Neville st., Perth Amboy (12)
 Saracino, Frank J., 124 Grand pl., Arlington (7)
 Schirber, Rene G., 11 Kirkpatrick st., N'wBrns.(12)
 Schwartz, Mortimer L., 450 Belmont av., Newark (7)
 Sheft, Matthew J., 100 Hope av., Passaic (16)
 Shinefeld, Maurice A., 669 Broadway, Paterson (16)
 Silberner, Herbert B., 104 Hillside av., Newark (7)
 Silver, George A., Jr., 242 Stockton st., Hightst'n (11)
 Silverman, S. Andrew, 556 15th av., Newark (7)
 Siniscal, Arthur A., 149 Prospect st., Passaic (16)
 Smith, Edward C., 111 4th av., Lakewood (15)
 Smith, Sidney, 15 S. 3rd av., Highland Park (12)
 Sokoloff, Oscar J., 67 Paterson st., NewBrunsw'k(12)
 Solomon, Harold, 249 Avon av., Newark (7)
 Sonnenberg, Arthur, Essex Mt. Sana., Verona (7)
 Steiner, Herbert, 650 Stuyvesant av., Irvington (7)
 Stoll, George F., 330 Washington av., Belleville (7)
 Strauss, Leo M., 18 S. Munn av., East Orange (7)

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ACTIVE MEMBERS

- Taber, Fred'k S., 129 Graham st., Highland Park (12)
 Taber, Leslie R., 266 Van Houten st., Paterson (16)
 Taft, Herman L., 16 48th st., Weehawken (9)
 Talmage, Wm. G., Main st., Succasunna (14)
 Talty, John C., 935 Washington st., Hoboken (9)
 Tanner, Monroe J., Paramus (2)
 Tannert, Carl H., 331 77th st., North Bergen (9)
 Tansey, William A., 98 Dover st., Newark (7)
 Taranto, Michael, 731 N. Wood av., Linden (20)
 Tarbell, Harold A., 13 Pennington st., Newark (7)
 Tataryan, Hovsep, 422 New York av., Union City (9)
 Tatem, Henry R., Jr., Pine st.&Atl.av.,Audubon(4)
 Tator, Arthur E., 57 De Forest av., Summit (20)
 Taylor, G. Herbert, 144 Harrison st., E. Orange (7)
 Taylor, Harold W., 247 Mountain rd., Englewood (2)
 Taylor, Malcolm C., 181 South st., Morristown (14)
 Taylor, Raymond A., 58 Madison av., Lakewood (15)
 Taylor, Walter A., 450 Rutherford av., Trenton (11)
 Teeter, Charles E., 418 Orange st., Newark (7)
 Teller, Daniel W., 28 DeHart st., Morristown (14)
 Tellman, Daniel H., 120 Lexington av., Passaic (16)
 Temes, J. Howard, 2216 Blvd., Jersey City (9)
 Temple, Arthur H., 164 Jefferson st., Passaic (16)
 Tenney, Albert S., 164 S. Harrison st., E. Orange (7)
 Tenney, Luman H., Princeton Univ., Princeton (11)
 Tennis, Edgar M., 375 Engle st., Englewood (2)
 Terhune, Percy H., 81 Millbr'k rd.,Hamden,Conn.(16)
 terKuile, Reinold W., 88W.Ridgew'd av.,Ridgew'd(2)
 Terrell, Edward E., 16 Alden st., Cranford (20)
 Terreri, D. Joseph, 30 High st., Morristown (14)
 Teskey, Stanley, 10 Anderson rd., Bernardsville (14)
 Tether, Russell K., Main st., Closter (2)
 Thalheimer, Edward J., 7th & Plum sts.,Vineland(6)
 Thomas, Claude W., 28 East av., Woodstown (17)
 Thomas, George N., 712 Wood st., Vineland (6)
 Thomas, Harry G., 1113 5th av., Asbury Park (13)
 Thomas, Irene O., 350 Lafayette av., Hawthorne(16)
 Thomas, John H., 270 Lenox av., South Orange (7)
 Thomas, Ralph B., 793 Montgomery st., Jer. City (9)
 Thomas, Thomas S., Jr., 18 Elm st., Morristown (14)
 Thomison, Harry E., 605 Broad st., Newark (7)
 Thompson, Arthur F., 144 Harrison st.,E.Orange(7)
 Thompson, Austin B., 479 Highland av., Orange (7)
 Thompson, Penrose H., 4612Westfield av.,Camden(4)
 Thompson, Theodore F., 316 First st., Lakewood (15)
 Thompson, Thomas M., 102 Pitman av., Pitman (8)
 Thomson, Carroll S., Fair Oaks Sana., Summit (7)
 Thorne, Nathan, 117 Chester av., Moorestown (3)
 Thorne, William P., 254 Main st., Butler (16)
 Thornhill, Arthur C., 47 Forest st., Montclair (7)
 Thornton, P. John S., Veterans Adminis., Lyons(18)
 Thron, Leopold E., 586 E. 29th st., Paterson (16)
 Tidaback, John D., 382 Springfield av., Summit (20)
 Tidwell, Harold F., 229 16th st., West New York (9)
 Tilles, Samuel, 44 Sheridan av., Seaside Heights (15)
 Tillis, Herman H., 11 Bergen st., Newark (7)
 Timberlake, Baxter H., 1616 Pacific av., Atl.City(1)
 Tirrell, C. Malcolm, 71 Lincoln Park, Newark (7)
 Toal, Joseph, 803 Prospect av., Ridgefield (2)
 Tobey, Franklin J., 11 Hazelwood av., Newark (7)
 Todd, Francis H., 83 Auburn st., Paterson (16)
 Tomaiuolo, Michele, 19 76th st., North Bergen (9)
 Tomec, Otto C., 756 Parkway av., Trenton (11)
 Tomec, Richard F., 42 Melrose pl., Montclair (7)
 Tomkins, Wm., 105 Fairmount rd., Ridgewood (16)
 Tomlins, Francis I., 11 Oak st., Ridgewood (2)
 Tomlinson, Rolland D., 445 E. Broad st.,Westf'd(20)
 Tompkins, Grenelle B., 52 Broad st., Flemington (10)
 Torppey, John J., 472 Sanford av., Newark (7)
 Towbin, Adolph, 326 Third st., Lakewood (15)
 Townsend, John B., 824 Wesley av., Ocean City (5)
 Townsend, Leslie M., 420 Chestnut st.,RoselleP'k(20)
 Toy, Calvert R., 22Kirkpatrick st.,NewBrunsw'k(12)
 Toye, John E., 90 Midland av., Arlington (7)
 Tracy, George T., 222 Warren st., Beverly (3)
 Trautwein, Chas. F., 131 Nesbit ter., Irvington (7)
 Treiber, Benjamin A., 219 W. State st., Trenton (11)
 Triarsi, Anthony J., 702 3rd av., Elizabeth (20)
 Trippe, Clarence M., 702 Asbury av., Asbury P'k(13)
 Tucker, Sidney, 182 Market st., Perth Amboy (12)
 Tuers, George E., 418 Park av., Paterson (16)
 Turi, Amedeo E., 57 Garside st., Newark (7)
 Turner, Charles F., 151 Grove st., Montclair (7)
 Turner, Isabel B., 141 Sheffield av., Englewood (2)
 Tushnet, Leonard, 662 18th av., Irvington (7)
 Tutschulte, Ernest, 111 Mt. Pleasant av., Newark(7)
 Tweddel, George K., 239 Broadway, Paterson (16)
 Twitchell, Adelbert B., 152 S.Orange av.,S.Orange(7)
 Tymeson, Walter R., 310 Main st., Orange (7)
 Tyndall, Alice E., 263 Walnut st., Westfield (20)
 Tyndall, Hugh H., 83 Highwood ter., Weehawken(9)
 Tyndall, Martha W., 263 Walnut st., Westfield (20)
 Tyrrell, George W., 380 State st., Perth Amboy (12)
 Tyson, Frances B., 101 Leonia av., Leonia (2)

ASSOCIATE MEMBERS

- Tanner, Walter L., N. J. State Hosp., Trenton (11)
 Tansey, Wm. A., Jr., 54 Baltusrol way,ShortHills(7)
 Thompson, Edward C., 373 Park av., Paterson (16)
 Thornley, Wm. F., 11 Ridgewood ter., Maplew'd (7)
 Tisch, Leon, 5 Russell av., Piscatawaytown (12)
 Toczek, Heinrich A., 404 Bergen st., Newark (7)
 Tunis, Benno B., 5 Farley av., Newark (7)
 Tutela, Arthur C., 220 S. 7th st., Newark (7)

U

ACTIVE MEMBERS

- Udinsky, Hyman J., 29 Passaic av., Passaic (16)
 Uhr, Jacques S., 127 Livingston av., NewBrun.(12)
 Ulan, Jerome, Main st., Spotswood (12)
 Ulan, Oscar, 170 Fleming av., Newark (7)
 Ulmer, Chester I., 431 W. Broad st., Gibbstown (8)
 Ulmer, D. H. Bartine, 199 Chestnut st., Moorestown (3)
 Ulvestad, Lawrence E., 147 Halsted st., E. Orange (7)
 Underwood, J. Harris, 509 N. Broad st., Woodbury (8)
 Upham, Helen F., 305 Third av., Asbury Park (13)
 Urbach, George, 187 Chancellor av., Newark (7)
 Urbaniak, Henry S., 883 Brunswick av., Trenton (11)
 Urbanski, Adrian X., 148 Market st., P'thAmboy (12)
 Urbanski, Matthew F., 314 W'sh'nt'n st., P'hAmb'y (12)
 Urevitz, Abraham, 2415 New York av., Union C'y (9)
 Utkewicz, Edmond A., 2756 Hudson Blvd., Jer.C'y (9)
 Uzzell, Edward F., 2703 Pacific av., Atlantic City (1)

V

ACTIVE MEMBERS

- Vaczi, Stephen, 983 S. Broad st., Trenton (11)
 Vail, William P., 522 Magnolia av., Orlando, Fla. (21)
 Vallario, Frank A., 333 Clifton av., Newark (7)
 Vanderbeek, James J., 281 Park av., Paterson (16)
 Vanderbeek, Andrew B., 174 Broadway, Paterson (16)
 Vanderbeek, Frank B., 407 Park av., Paterson (16)
 Vanderbeek, Stuart W., 143 Engle st., Englewood (2)
 Vander Clock, Cornelius, 23 Passaic av., Passaic (16)
 Vander Veer, H. Garrett, 295 M'tg'm'ry st., Bl'mf'd (7)
 Van Deusen, Edwin H., 12 N. 7th st., Vineland (6)
 van Dyke, Harry B., 501 Central av., Stelton (12)
 Van Dyke, Jos. S., 42 Palisade Blvd., Palisades P'k (2)
 Van Eerde, Albert, 339 Lafayette av., Hawthorne (16)
 Van Emburgh, Geo. H., 575 Belgrove dr., Alr'gt'n (7)
 Van Gieson, Edward J., 70 Watsessing av., Bl'mf'd (7)
 Vann, Felix H., 201 E. Palisade av., Englewood (2)
 Vannatta, George W., 226 N. Park st., E. Orange (7)
 Vanneman, Joseph S., 45 Princeton av., Princet'n (11)
 Van Ness, H. Roy, 444 Parker st., Newark (7)
 Van Riper, A. Ward, 605 Main av., Passaic (16)
 Van Schott, Gerard J., Jr., 245 Lex'gt'n av., Pas'c (16)
 Van Sciver, John E. L., 106 Broadway, Camden (4)
 Van Sickle, Albert W., Chester (14)
 Van Urk, Frederick T., 422 Lexington av., Clifton (16)
 Van Winkle, Charles L., 79 Ridge rd., Rutherford (2)
 Van Winkle, John S., 297 Broadway, Paterson (16)
 Varney, Wm. H., 122 Belvidere av., Washington (21)
 Varriano, John L., 3263 Boulevard, Jersey City (9)
 Venturo, Ralph C., 101 S. Main st., Glassboro (8)
 Verbeck, Geo. B., 20 Church av., Ballston Spa, N.Y. (7)
 Vermes, Leslie, 172 Main st., Franklin (19)
 Vermeulen, Abram, 344 Haledon av., Prospect P'k (16)
 Villapiano, Jos. G., 701 Sunset av., Asbury Park (13)
 Villegas, Juan A., 406 Lafayette av., Cliffside Park (2)
 Vincent, Nicholas F., 144 S. Harrison st., E. Orange (7)
 Vinciguerra, Michael, 604 Westm'st'r av., Elizab'h (20)
 Virgilio, Anthony A., 87 S. Centre st., Orange (7)
 Visconti, Joseph A., 711 Garden st., Hoboken (9)
 Vita, Frank J., 595 Palisade av., Cliffside Park (2)
 Vitale, Dominic V., 681 Newark av., Elizabeth (20)
 Viteri, Luis E., 214 High st., Mt. Holly (3)
 Vitolo, Ralph E., 934 Orchard ter., Linden (20)
 Vogel, H. Austin, 1060 E. Jersey st., Elizabeth (20)
 Vol-Tretter, Marta, 501 W. State st., Trenton (11)
 von Deilen, Henry O., 28 DeHart st., Morristown (14)
 Von Hofe, Frederick H., 75 Prospect st., E. Orange (7)
 Voorhees, Florence E., 140 Roseville av., Newark (7)
 Voorhies, Wm. S., Jr., N.J. State Hosp., Gr'st'ne P'k (14)
 Vosburgh, Fred, 61 Passaic av., Passaic (16)
 Voss, J. Landon, 21 Mt. Airy rd., Bernardsville (14)
 Voss, John C., 634 Thomas av., Riverton (3)
 Vostrosablin, Nicholas A., 121 Grand st., Jer. City (9)
 Vreeland, Ralph D., 400 Highland ter., Orange (7)
 Vreeland, Ralph J., 266 Van Houten st., Paterson (16)
 Vreeland, Wm. N., 32 Bergen av., Jersey City (9)
 Vroom, Wm. L., 88 W. Ridgewood av., Ridgewood (2)

ASSOCIATE MEMBERS

- Valentin, Irmgard, 131 S. Harrison st., E. Orange (7)
 Vento, Sebastian J., 1330 S. Clinton av., Trenton (11)
 Visceglia, Frank R., 99 Gregory av., Passaic (16)

W

ACTIVE MEMBERS

- Wacker, Wm. F., 1224 Salem av., Hillside (20)
 Wade, Francis A., 196 South st., Morristown (14)
 Wade, Simon F., 555 Newark av., Elizabeth (20)
 Wagner, J. George, Riverbank, Delanco (3)
 Wagner, John, 127 Wilson av., Newark (7)
 Wagner, Richard, 612 N. Broad st., Elizabeth (20)
 Wakeley, Wm. E., 144 Harrison st., E. Orange (7)
 Waldron, Edward L., 126 W. State st., Trenton (11)
 Waldron, Robert E., 1194 Broad st., Bloomfield (7)
 Walker, Ada H., 635 Landis av., Vineland (6)
 Walker, Harold G., Everett av., Wyckoff (16)
 Walker, H. Burton, 635 Landis av., Vineland (6)
 Walker, Levi M., 110 S. No. Carolina av., Atl.C'y (1)
 Walker, Robert B., 108 Church st., N'wBrunsw'k (12)
 Wallace, Marc J., 165 Lakeview av., Clifton (16)
 Wallach, Bernard, 74 Watchung av., N. Plainf'd (18)
 Wallack, Eli A., 333 Fairmount av., Jersey City (9)
 Wallhauser, Henry J. F., P'nn-Stroud, Str'dsb'g, Pa. (7)
 Wallin, Alfred C., 166 Main st., Matawan (13)
 Walscheid, Arthur J., 404 38th st., Union City (9)
 Walsh, Chas. R., 21 W. Mt. Pl'sant av., Liv'gst'n (7)
 Walsh, Ronald J., 118 E. 5th av., Roselle (20)
 Walsh, Thomas J., 514 Greenwood av., Trenton (11)
 Walsh, Thomas J., 335 S. Broad st., Elizabeth (20)
 Walsh, Thomas M., 210 Kipp av., Hasb'k Hgts. (2)
 Walters, George M., 158 Main st., Woodbridge (12)

- Walton, Gordon G., 17 Church st., Paterson (16)
Walton, Ralph W., 102 Gates av., Montclair (7)
Wambsganss, Magdalena, 44 Devine st., Newark (7)
Wandall, Fred'k G., 50 E. High st., Clayton (8)
Wanger, Wm. F., 102 Broad st., Bloomfield (7)
Warburton, Jack C., 333 Park av., Paterson (16)
Ward, Albert H., 404 Totowa av., Paterson (16)
Ward, Albert J., 39 Elm st., Morristown (14)
Ward, Elisabeth B., 112 Chancellor av., Newark (7)
Ward, Gertrude P., 41 Park pl., Bloomfield (7)
Ward, Leo J., 137 W. Jersey st., Elizabeth (20)
Ward, William R., 112 Chancellor av., Newark (7)
Ward, Wm. R., Jr., 112 Chancellor av., Newark (7)
Ware, Carl N., Bridgeton rd., Shiloh (6)
Ware, F. Vernon, 223 N. 2nd st., Millville (6)
Warner, Wm. H. A., 444 Central av., E. Orange (7)
Warren, Chas. B., 181 Prospect av., Bergenfield (2)
Warren, David E., 154 Broadway, Passaic (16)
Warren, Earl L., 266 Van Houten st., Paterson (16)
Warren, Jacob, 308 18th av., Paterson (16)
Warter, Peter J., 717 W. State st., Trenton (11)
Warwick, Ralph A., 3300 Federal st., Camden (4)
Washburn, Philip C., N. J. St.Hosp., Gr'y'st'neP'k(14)
Wassing, Hans, 695 Broadway, Paterson (16)
Waterman, Samuel M., 364 Clinton av., Newark (7)
Waters, Chas. H., 928 W. State st., Trenton (11)
Waters, Edward G., 39 Gifford av., Jersey City (9)
Watkins, George R., La Pierre rd., Magnolia (4)
Watkins, Robert E., 517 5th av., Belmar (13)
Watman, Anthony J., 2786 Boulevard, JerseyCity(9)
Watov, Samuel E., 615 Beatty st., Trenton (11)
Watson, Frederick S., 238 W. State st., Trenton (11)
Watts, Wilbur, 436 E. State st., Trenton (11)
Waugh, Bascomb S., 1882 S. 10th st., Camden (4)
Way, Clarence W., Landis av.&46th st.,SeaIsleC'y(5)
Wayman, Bernard R., 834Stuyvesant av.,Trent'n(11)
Wayne, David M., Box 410, Redfield, S. Dakota (7)
Webb, Eleanor A., 887Spr'g'd av.,NewPr'vid'nce(20)
Webb, Wilson D., 316 State st., Hackensack (2)
Weber, Francis C., 286 Mt. Prosp't av., Newark (7)
Weber, John F., 264 Main st., South Amboy (12)
Weber, Walter D., 305 23rd st., Union City (9)
Wechsler, Jos., 3342 Hudson Blvd., Jersey City (9)
Weeks, Norman E., 470 Grove st., Up. Montclair(7)
Weems, Don B., 105 E. Mantua av., Wenonah (8)
Wegryn, Louis S., 257 Elizabeth av., Elizabeth (20)
Weigel, Charles F. B., 328 E. Broadway, Salem (17)
Weigel, Edgar W., 970 Park av., Elizabeth (20)
Weigel, Elmer P., 727 Watchung av., Plainfield (20)
Weimann, Max L., 803 Station av., Haddon Hgts.(4)
Weiner, Henry T., 111 Market st., Perth Amboy (12)
Weiner, Samuel E., 904 Pacific av., Atlantic City (1)
Weinert, Henry V., 128 Market st., Passaic (16)
Weinmann, Max H., 714 Scotland rd., Orange (7)
Weinstein, Francis S., 189 16th av., Newark (7)
Weinstein, Morris W., 643 Chancellor av.,Irv'gt'n(7)
Weinstock, Michael E., 13 Hillside av., Newark (7)
Weintraub, Wm. L., 400 Broadway, Paterson (16)
Weisman, Stephen L., 566 Broadway, Paterson (16)
Weiss, Abram, 2302 Palisade av., Weehawken (9)
Weiss, Herman, Aurora Institute, Morristown (14)
Weiss, Louis, 519 Springfield av., Newark (7)
Weiss, Morris J., 734 Ave. C. Bayonne (9)
Weiss, Selma, 2 Stratford pl., Newark (7)
Weissman, Meyer T., 947 E. Jersey st., Elizabeth(20)
Weithaase, Helen E., 8th and Elmer sts.,Vineland(6)
Welcher, Howard A., 7904 HudsonBlvd.,N.Bergen(9)
Weller, Arthur, 19 Hillyer st., Orange (7)
Weltchek, Herbert, 240 Lincoln av., Elizabeth (20)
Wentzell, J. Earl, 5 E. Mantua av., Wenonah (8)
Wescott, Wm. C., Delaware & Pacific avs.,Atl.City(1)
West, David H., 517 Cooper st., Camden (4)
West, Edgar L., 443 E. State st., Trenton (11)
West, Gordon F., 527 Penn st., Camden (4)
Westerhoff, Peter D., 51 Highl'd av., MidlandP'k(16)
Western, Frederic B., 1227 Morris av., Townley (20)
Westney, Alfred W., 3005 Pacific av., Atl. City (1)
Weston, Clifford G., 27 Woodland av., Glen Ridge(7)
Wethers, William A., 171 Market st., Passaic (16)
Wetterberg, Louis F., 74 Grove av., Woodbridge (12)
Whaland, Berta, 117 Atlantic st., Bridgeton (6)
Wheatland, Marcus F., 727 Walnut st., Camden (4)
Wheeler, James A. V., 85 Van Reyepen st.,Jer.C'y(9)
Wheeler, William K., 31 Lincoln Park, Newark (9)
Whelan, Edward P., 460 Franklin av., Nutley (7)
Wherry, Elmer G., 325 Clinton av., Newark (7)
Whims, Clarence B., 5401 Ventnor av., Ventnor (1)
Whinery, Jos. F., 53 Templar pl., Summit (20)
Whitaker, Henry J., 10 S. Broadway, Pitman (8)
White, Frank S., 916 Red road, Teaneck (2)
White, Harry J., Roosevelt Hospital, Metuchen (12)
White, Hugh M., 901 Summit av., Jersey City (9)
White, R. Rostin, 644 Shore rd., Somers Point (1)
White, Richard E., 303 Crooks av., Paterson (16)
White, Robert R., 25 S. Munn av., East Orange (7)
White, Thomas J., 50 Glenwood av., Jersey City (9)
Whiticar, John H., 717 Wesley av., Ocean City (5)
Whitken, Albert I., 1056 North av., Elizabeth (20)
Whitman, Lloyd B., 7 W. Clinton av., Bergenfield(2)
Whittaker, Neil M., 418 Main st., Hackensack (2)
Widetsky, Alfred, 85 Broadway, E. Paterson (2)
Wiesler, Howard M., 128 Third st., Trenton (11)
Wikoff, John L., 799 Pennington av., Trenton (11)
Wilbur, Franklin L., 711 Grand av., Asbury P'k(13)
Wilcox, Frank A., 329 16th st., West New York (9)
Wild, Frederick A., 111 E. High st., Bound Br'k (18)
Wilentz, Wm. C., 188 Market st., Perth Amboy (12)
Wilkes, LeRoy A., 143 E. State st., Trenton (11)
Wilkins, Stanley O., 47 E. Front st., Red Bank (13)
Willan, Edward H., 74 S. Munn av., E. Orange (7)
Willey, F. Parker, 153 Roseville av., Newark (7)
Williams, David P., 284 Morris av.,MountainLks.(14)
Williams, Frank A., 324 W. Jersey st., Elizabeth(20)
Williams, George W., 829 W. State st., Trenton (11)
Williams, Harry D., 527 E. State st., Trenton (11)
Williams, Hiram, 230 Lexington av., Passaic (16)
Williams, John J., 88 Walnut st., Newark (7)
Williams, Leonard D., 915 Park av., Plainfield (20)
Williams, Louis E., 80 Green av., Madison (14)
Williams, Wm. C., 9 Ridge rd., Rutherford (2)
Williamson, Wm. L., 22 W. 22nd st., Bayonne (9)
Willis, Benedict P., 185 Montross av., Rutherford(2)
Willis, Katharen C., 31 Trinity pl., Montclair (7)
Wilner, Irving, 18 Waverly av., Newark (7)
Willner, Philip, 105 Clinton av., Newark (7)
Willson, James H., 144 Harrison st., E. Orange (7)
Wilner, Arthur S., 205 Market st., Trenton (11)
Wilson, Charles W., 636 Wood st., Vineland (6)
Wilson, Harrison B., 430 Union st., Hackensack (2)
Wilson, Herbert H., 24 Bank st., Bridgeton (6)
Wilson, John H., Jr., 85 Halsted st., E. Orange (7)
Wilson, Lawrence A., 114 N. Shore rd., Absecon (1)
Wilson, Lester R., 3320 Federal st., Camden (4)
Wilson, Robert B., 91 Broad st., Red Bank (13)
Winn, Samuel L., 1616 Pacific av., Atlantic City (1)
Winslow, John H., 27 S. Valley av., Vineland (6)
Winter, Gladys C., 717 Norma court, Teaneck (2)
Winters, Walter M., 288 Broadway, Paterson (16)
Wise, Lester D., 119 Morris av., Long Branch (13)
Wishnack, Meyer, 318 Broadway, Paterson (16)
Witkoff, Ben, 215 Terrace av., Hasbrouck Heights(2)
Witmer, John D., 456 Middlesex av., Metuchen (12)
Witte, C. Norman, 422 River av., P't Pleasant (15)
Wittenborn, Wm. F. J., 1635Br'ns'w'k av.,Tr'nt'n(11)
Woelfle, Henry E., 907 Summit av., Jersey City (9)
Wolbert, Chas. M., 691 Palisade av., CliffsidePark(9)
Wolf, Israel J., 231 E. 31st st., Paterson (16)
Wolf, Raymond E., 281 Park st., Upper Montel'r(7)
Wolfe, Jacob S., 44 Watessing av., Bloomfield (7)
Wolfe, Wm. W., 383 Mulberry st., Newark (7)

- Wolff, Herbert M., 732 W. State st., Trenton (11)
 Wolff, Jerome M., 1414 Martine av., Plainfield (20)
 Wolfson, Harry, 356 Park av., Paterson (16)
 Wolgin, Philip L., 445 Elmora av., Elizabeth (20)
 Wood, E. LeRoy, 160 Roseville av., Newark (7)
 Wood, Oran A., 128 W. Broad st., Paulsboro (8)
 Woodman, Chas. B., 26 Maple av., Morristown (14)
 Woodruff, Dare, 630 Landis av., Vineland (6)
 Woodruff, Ralph G., Main st., Englishtown (13)
 Woodruff, Stanley R., 16 Enos pl., Jersey City (9)
 Woody, McIver, 454 Union av., Elizabeth (20)
 Woolf, Bernhardt H., 15 Hedden ter., Newark (7)
 Worcester, George F., 220 Engle st., Englewood (2)
 Woronoff, Murray, 120 Main st., Keyport (13)
 Wort, Frederick J., 1080 Broad st., Newark (7)
 Wrensch, Alexander E., 79 Valley rd., Montclair (7)
 Wright, Ada V. A., State Home for Girls, Trenton (11)
 Wright, Herman W., 818 S. Broadway, Pitman (8)
 Wright, Ralph S., 428 Richey av., W. Collingsw'd (4)
 Wright, Robert E., 173 Park av., East Orange (7)
 Wroblewski, Benjamin M., 1166 Th'rm'n st., C'md'n (4)
 Wry, Dean A., 234 Dayton av., Clifton (16)
 Wry, Orlin V., 95 High st., E. Rutherford (2)
 Wuester, Wm. O., 238 Exter way, Hillside (20)
 Wurts, Margaret M., 189 Alexander av., Up. M'tcl'r (7)
 Wurzel, Milton, 295 Hunterdon st., Newark (7)
 Wyatt, Joseph H., 135 Clinton av., Newark (7)
 Wyker, Arthur W., 57 Park pl., Bloomfield (7)
 Wyman, Edward H., 100 E. Broad st., Burlington (3)

ASSOCIATE MEMBERS

- Wainright, Melvin A. R., 286 Broad st., Red Bank (13)
 Walker, Otto, 72 Roosevelt av., Carteret (12)
 Weinberg, Alfred, 654 Lyons av., Irvington (7)
 Wesson, Harrison R., 15 The Crescent, Montclair (7)
 Wiener, David, 196 Weequahic av., Newark (7)
 Wildmann, George A., 1720 S. Broad st., Trenton (11)
 Wilner, Irving, 205 Market st., Trenton (11)
 Winter, Egon W., 825 S. 10th st., Newark (7)
 Wolf, Erich, 158 Broadway, Passaic (16)
 Wuerthele, Virginia E., 311 Mt. Prosp't av., Newk (7)

Y

ACTIVE MEMBERS

- Yadkowsky, Emanuel, 637 High st., Newark (7)
 Yaeger, Leslie A., 470 Hamilton av., Trenton (11)
 Yager, J. Allen, 420 Broadway, Paterson (16)
 Yagol, Benjamin, Bonnie Burn Sana., Scotch Pls. (20)
 Yaguda, Asher, 88 Clinton av., Newark (7)
 Yates, Glen L., 270 Ridgewood av., Glen Ridge (7)
 Yates, John S., 414 Ellison st., Paterson (16)
 Yazujian, Dikran M., 562 E. State st., Trenton (11)
 Yeaton, Wm. L., Jr., 204 11th st., Hoboken (9)
 Yellin, Charles H., 525 E. 2nd av., Roselle (20)
 Ylvisaker, Lauritz S., 763 Broad st., Newark (7)
 Yolken, Harry, 246 E. 31st st., Paterson (16)
 Yood, Raphael, 401 Grant av., Plainfield (20)
 York, James L., 331 River rd., New Milford (2)
 York, Wilbur H., 87 Battle rd., Princeton (11)
 Young, Franklin C., 120 Summit av., Summit (20)
 Young, George J., 60 Maple av., Morristown (14)
 Young, James L., 68 Mountain av., Somerville (18)
 Yuckman, Robert O., 224 W. Jersey st., Elizabeth (20)
 Yudkoff, William, 403 Boulevard, Bayonne (9)

ASSOCIATE MEMBERS

- Yablonsky, Max, 171 Osborne ter., Newark (7)
 Yoskalka, J. S., 107 Med. R., 32d Div., C'p Liv'gst'n. La. (7)

Z

ACTIVE MEMBERS

- Zacchino, Arnold A., 1001 Anderson av., Palisade (2)
 Zager, Saul, 454 Hawthorne av., Newark (7)
 Zalewski, Irene J., 125 Market st., Passaic (16)
 Zandt, Frederic B., 16 Mercer st., Hamilton Sq. (11)
 Zapf, Reville D., 100 W. Mantua av., Wenonah (8)
 Zappala, John, 47 W. Main st., Pennsgrove (17)
 Zehnder, A. Charles, 188 Roseville av., Newark (7)
 Zeitlin, Herman H., 943 N. Wood av., Linden (20)
 Zimmer, William, 1 Hillside av., Newark (7)
 Zimmerman, Coler, 52 N. Arlington av., E. Orange (7)
 Zimmerman, Robt. F., 28 W'sh'gt'n av., Morrist'n (14)
 Zimskind, Joshua N., 210 W. State st., Trenton (11)
 Zingales, Joseph A., 101 Holly st., Cranford (20)
 Zingali, John A., 55 Grove st., Montclair (7)
 Zitani, Alfred M., 937 Washington st., Hoboken (9)
 Zuck, John A., Main st., Netcong (14)
 Zuckerman, David E., 345 Broadway, Paterson (16)
 Zweibel, Leonard, 871 S. 11th st., Newark (7)
 Zweigel, Isidore, 22 Monticello av., Newark (7)
 Zybulewski, Edmund A., 410 Bergen st., Newark (7)

MEMBERSHIP OF COUNTY MEDICAL SOCIETIES

Comprising THE MEDICAL SOCIETY OF NEW JERSEY ON MARCH 15, 1941

An asterisk (*) indicates a deceased member

ATLANTIC COUNTY (1)

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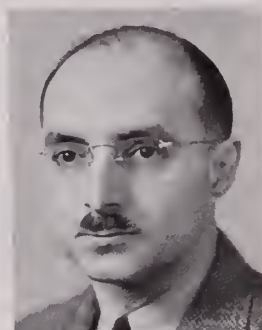
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President
Atlantic City



J. CARLISLE BROWN
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Atlantic City



DAVID B. ALLMAN
Treasurer
Atlantic City



CHARLES HYMAN
Reporter
Atlantic City

Society organized June 7, 1880. Meets second Friday evening monthly, except in June, July and August. Annual Meeting in May.

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Bassett, Norman H., 1616 Pacific av., Atlantic City
Beir, Ily R., 3900 Atlantic av., Atlantic City
Bossert, Charles L., 4021 Atlantic av., Atlantic City
Boysen, Theophilus H., 100 Phila. st., Egg Harbor City
Bradley, Robt. A., 1616 Pacific av., Atlantic City
Brown, J. Carlisle, 101 S. Indiana av., Atlantic City
Carrington, Wm. J., 905 Pacific av., Atlantic City
Chalfant, W. Paxson, Jr., 7003 Ventnor av., Ventnor
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Clark, S. Worth, 152 S. No. Carolina av., Atlantic City
Cleary, Jos. P., Minotola
Conaway, Walt P., 1723 Pacific av., Atlantic City
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Crane, Bernard, 306 Pacific av., Atlantic City
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deHellebranth, Roland T., 104 S. Portland av., Ventnor
Diskan, Samuel M., 1904 Pacific av., Atlantic City
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Durham, Royal E., 100 S. New Haven av., Ventnor
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Ewens, Arthur E., 3600 Pacific av., Atlantic City
Feinstein, Louis, 410 Pacific av., Atlantic City
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Frank, Myrtile, 227 Philadelphia av., Egg Harbor City
Goldstein, Samuel, 16 E. Main st., Mays Landing
Gorden, Benjamin L., 1616 Pacific av., Atlantic City
Gottlieb, Morris, 1616 Pacific av., Atlantic City

Grier, Robt. M., 50 E. Washington av., Pleasantville
Gross, Max, 109 States av., Atlantic City
Guion, Edward, Shore rd., Northfield
Halpern, Samuel, 504 Pacific av., Atlantic City
Harley, Halvor L., 101 S. Indiana av., Atlantic City
Henderson, Kenneth P., Ansley Park, Pleasantville
Hersohn, Wm. W., 116 S. Illinois av., Atlantic City
Hoffman, Harry S., 3302 Pacific av., Atlantic City
Holmes, H. David, 1813 Arctic av., Atlantic City
Holoman, M. Browne, 1 No. Haverford av., Margate
Holt, Edward Z., 4100 Atlantic av., Atlantic City
Hudson, Woodburn J., 39 E. Washington av., Pleasantville
Hyman, Chas., 2619 Pacific av., Atlantic City
Infield, Gerald L., 1401 Shore rd., Northfield
Jacobson, J. Joseph, 1616 Pacific av., Atlantic City
Johnson, V. Earl, 101 S. Indiana av., Atlantic City
Kahn, Leo, 32 States av., Atlantic City
Kaighn, Chas. B., 905 Pacific av., Atlantic City
Kilduffe, Robt. A., Atlantic City Hosp., Atlantic City
Kline, Herman, 2643 Pacific av., Atlantic City
Krechmer, Abraham, 521 Pacific av., Atlantic City
Lawther, Boyd M., 1401 Shore rd., Northfield
Leonard, Isaac E., 2842 Atlantic av., Atlantic City
Leonard, Isaac E., Jr., 2842 Atlantic av., Atlantic City
Madden, Leland S., 21 E. Verona av., Pleasantville
Magill, Marcus, 4116 Ventnor av., Atlantic City
Major, Morton M., 4212 Ventnor av., Atlantic City
Marshall, H. Donald, 611 N. Indiana av., Atlantic City
Mason, James H., 1616 Pacific av., Atlantic City
McGovern, Chas. S., 805 Pacific av., Atlantic City
McVay, James C., 2907 Pacific av., Atlantic City
Mishier, Jay E., 805 Pacific av., Atlantic City
Molitch, Matthew, 705 Pacific av., Atlantic City
Nickman, E. Harrison, 4702 Atlantic av., Atlantic City
Pennington, John, 101 S. Indiana av., Atlantic City
Pilkington, Albert, 117 S. Virginia av., Atlantic City

Poland, Geo. A., 206 E. Verona av., Pleasantville
 Quinn, Norman J., 3303 Pacific av., Atlantic City
 Read, Hilton S., 5407 Atlantic av., Ventnor
 Reyner, Daniel C., 2703 Pacific av., Atlantic City
 Rieck, Allan, 507 S. Shore rd., Pleasantville
 Rise, Wilson S., 5402 Ventnor av., Atlantic City
 Roop, William O., 101 S. Indiana av., Atlantic City
 Rosenberg, Louis, 26 S. Stenton pl., Atlantic City
 Rosenblatt, Sidney, 1904 Pacific av., Atlantic City
 Rubba, Russell R., 21 Horton st., Hammonton
 Ruffu, Henry L., 111 S. Boston av., Atlantic City
 Salasin, Samuel L., 511 Pacific av., Atlantic City
 Scanlan, D. Ward, 15 S. Illinois av., Atlantic City
 Schwarzkopf, Geo. C., 2901 Pacific av., Atlantic City
 Schwinn, Chas., 7600 Winchester av., Margate City
 Shenfeld, Isaac, 4806 Atlantic av., Ventnor
 Shimer, A. Burton, 606 Pacific av., Atlantic City

Shivers, Chas. H. deT., 121 S. Illinois av., Atl. City
 Sinkinson, Chas. D., Jr., 1616 Pacific av., Atlantic City
 Smith, Andrew M., 344 Phil'd'lphia av., Egg H'rbr' City
 Stamps, G. Ruffin, 300 E. Verona av., Pleasantville
 Stern, Samuel, 2815 Pacific av., Atlantic City
 Stewart, Sloan G., N. Caro. and Pac. avs., Atl. City
 Stewart, Walter B., 8 N. Tallahassee av., Atlantic City
 Subin, Harry, 1616 Pacific av., Atlantic City
 Timberlake, Baxter H., 1616 Pacific av., Atlantic City
 Uzzell, Edward F., 2703 Pacific av., Atlantic City
 Walker, Levi M., 110 S. No. Carolina av., Atl. City
 Weiner, Samuel E., 904 Pacific av., Atlantic City
 Wescott, William C., Pacific & Delaware avs., Atl. City
 Westney, Alfred W., 3005 Pacific av., Atlantic City
 Whims, Clarence B., 5401 Ventnor av., Ventnor
 White, R. Rostin, 644 Shore rd., Somers Point
 Wilson, Lawrence A., 114 N. Shore rd., Absecon
 Winn, Samuel L., 1616 Pacific av., Atlantic City

Number of Active Members and basis of representation, 107, on March 15, 1941

Courtesy Members

Barab, Barney B., D.D.S., Atlantic City
 Mally, Manuel J., D.D.S., Atlantic City
 Von Deilen, Arthur W., D.D.S., Atlantic City

Philips, Charles F., D.D.S., Atlantic City
 Steigerwald, Clarence S., D.D.S., Atlantic City

Honorary Members

Brown, Mr. Elmer W., Atlantic City
 Farley, Hon. Frank S., Atlantic City
 Haneman, Hon. Vincent S., Atlantic City

Marcus, Joseph H., Atlantic City
 Martin, William, Atlantic City
 Taggart, Major Thomas D., Atlantic City

Transfer

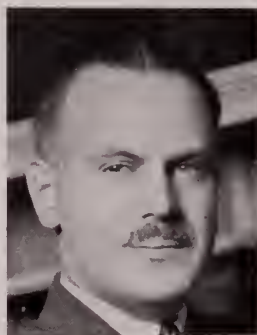
Gross, Max, from Hunterdon County

BERGEN COUNTY (2)

OFFICERS



RUSSELL K. TETHER
President
Closter



G. BARTON BARLOW
Secretary
Englewood



WILLIAM K. HARRYMAN
Treasurer
Hackensack



SAMUEL C. BUMP
Reporter
Ridgewood

Society organized February 28, 1854. Meets on second Tuesday of each month, except July and August. Annual Meeting in May.

Active Members

Abbate, Charles C., 32 Main st., Lodi
 Agayoff, John D., 127 S. Washington av., Bergenfield
 Alexander, Samuel, 12 Main st., Park Ridge
 Anderson, Reuben M., 408 Main st., Hackensack
 Angelillis, Paul, 76 State st., Hackensack
 Appold, George D., 60 E. Church st., Bergenfield
 Baketel, H. Sheridan, 155 Van Wagenen av., Jer. City
 Baldwin, John F., 1474 Windsor rd., W. Englewood
 Balze, Henry R., 147 Christie st., Leonia

Banta, Raymond E., 118 E. Clinton av., Tenafly
 Barbash, Roslyn H. W., 835 Red rd., Teaneck
 Barlow, G. Barton, 157 Engle st., Englewood
 Barnes, Wm. J., 155 Engle st., Englewood
 Baron, Herbert A., 150 Terrace av., Hasbrouck Heights
 Basralian, Joseph B., 238 Blvd., Hasbrouck Heights
 Beres, Albert J., 492 Wood-Ridge av., Wood-Ridge
 Berke, Raynold N., 430 Union st., Hackensack
 Bickner, Alvah W., 84 Park av., Rutherford

- Black, LeRoy W., 33 W. Passaic av., Rutherford
Blauvelt-Wells, Grace B., 76 Heights rd., Ridgewood
Bleasby, Charles B., 136 Passaic av., Garfield
Blenkle, Victor A., 140 Chadwick rd., Teaneck
Bookstaver, Barnet S., 193 Norma rd., Teaneck
Bosch, Taeke, Goffle Hill rd., Wyckoff
Branon, Mark E., 16 W. Passaic av., Rutherford
Bregman, Alexander, 2 Dempsey av., Edgewater
Brennan, Alfred T. V., Jr., 275 Engle st., Englewood
Brown, John L., 647 Anderson av., Grantwood
Brown, Leonard, 190 Park st., Ridgefield Park
Buckley, Paul J., 159 Palisade av., Bogota
Bump, Samuel C., 65 N. Maple av., Ridgewood
Burnham, Lyman, 229 Engle st., Englewood
Burns, Geoffrey C. H., County rd., Demarest
Busicco, Philip S., 131 Liberty rd., Englewood
Byers, Clarence W., 176 Union av., Rutherford
Calabrese, D. John, 139 Rochelle av., Rochelle Park
Campbell, James M., 101 S. Central av., Ramsey
Candio, Vincent P., 347 Ridge rd., Lyndhurst
Carbone, Ralph, Camp Livingston, La.
Carroll, Thomas R., 754 Anderson av., Grantwood
Cartneck, Louis C., 228 Hillcrest av., Wood-Ridge
Caruso, Paul F., 196 Hackensack st., Wood-Ridge
Caseiano, Adolph D., 42 Ridgefield av., Ridgefield P'k
Chase, Kalman, Jr., 80 Sheridan av., Hohokus
Christensen, Osborne F., 326 Madison av., Hasb'kHts.
Clarie, D'Arcy C., 558 Broad av., Ridgefield
Clarke, Edward W., 435 Warwick av., W. Englew'd
Clock, Ralph O., 20 Ridgcrest, W., Scarsdale, N. Y.
Cloud, Albert W., Huguenot av., Englewood
Cochrane, Cleland D., Main st., Closter
Connor, Clarence A., 1586 Center av., Fort Lee
Cooke, H. Hamilton, 100 Prospect st., Ridgewood
Corn, David, 119 Park st., Ridgefield Park
Costabile, Vincent, 150 Ridge rd., Rutherford
Coughlin, Joseph J., 340 Queen Anne rd., Teaneck
Crandall, John K., 200 Main st., Fort Lee
Cropsey, Chas. D., 168 Chestnut st., Rutherford
Curtis, Donald A., 241 Union st., Hackensack
D'Agastin, Henry, 243 Fulton ter., Cliffside Park
D'Amato, Charles R., 324 Hoboken rd., E. Rutherford
Dayton, Spencer T., 86 W. Demarest av., Englewood
Decker, John G., 216 Blvd., Hasbrouck Heights
Demarest, J. Willis, 124 Elm av., Hackensack
Denig, Ralph D., 370 State st., Hackensack
DeSanto, A. M., Summit av. and Essex st., Hack'ns'k
Deull, William D., 430 Union st., Hackensack
Dezer, Chas. N., Jr., 210 Main st., Hackensack
Dickson, John D., 202 Larch av., Bogota
Dilger, Frederick G., 210 Main st., Hackensack
Edwards, J. Bennett, 144 Woodridge pl., Leonia
Ellmers, B. J., 230 New Milford av., New Milford
Essertier, Edward P., 273 State st., Hackensack
Evans, J. Lawrence, Jr., 254 Christie Hgts., Leonia
Farmer, Vincent, 288 State st., Hackensack
Farr, Walter J., 288 Griggs av., Teaneck
Fechner, Fred J., 846 Garrison av., Teaneck
Fermaglich, Harry B., 881 Garrison av., Teaneck
Ferrari, Andrew F., 110 Hackensack st., E. Rutherford
Fessler, William, 31 Knox av., Grantwood
Fietti, Vincent G., 15 Ridge rd., Lyndhurst
Finke, George W., 237 State st., Hackensack
Finke, John H. D., 19 Hudson st., Hackensack
Fitzhugh, Wm. F., 190 Euclid av., Ridgefield Park
Fitzpatrick, Leo J., 134 Bergen av., Ridgefield Park
Fliegel, Wm. M., 85 W. Passaic st., Maywood
Forte, F. Chester, 111 State st., Hackensack
Freeland, Frank, 281 State st., Hackensack
Friedman, Abraham I., 280 State st., Hackensack
Gershman, Jos. G., 185 E. Madison av., Dumont
Gilady, Raphael, 205 Union st., Hackensack
Gittelsohn, Isador, 896 Kinderkamack rd., RiverEdge
Gladstone, Albert L., 404 Hickory av., Paramus
Goldberg, David, 7 Bogert pl., Westwood
Goldfarb, Abraham, 52 Chestnut st., Rutherford
Gould, Werner, 219 Passaic st., Hackensack
Gramsch, A. Louis, Bergen Pines, Oradell
Greenfield, Arthur W., 50 Anderson st., Hackensack
Greenfield, Wm. J., 50 Anderson st., Hackensack
Grimes, Jesse R., 214 Washington av., Dumont
Grimes, Robert R., 455 Queen Anne rd., Teaneck
Groff, Parker A., 159 Washington av., Little Ferry
Grueninger, Edward F., 24 Columbia av., Cliffside P'k
Hallett, Frederick S., 200 Passaic st., Hackensack
Halpern, Herman, 143 Engle st., Englewood
Halpern, Jesse O., 135 E. Madison st., Dumont
Harryman, Wm. K., 271 Union st., Hackensack
Hawes, Vernon L., 63 Church st., Ramsey
Helff, Joseph R., 1367 Teaneck rd., W. Englewood
Heller, Geo., 460 Engle st., Englewood
Hensle, Otto S., 5 Pangborn pl., Hackensack
Hillsman, Robt. B., 268 Vandelinda av., Teaneck
Hitzemann, Louis A., 30 E. Passaic st., Maywood
Horowitz, Herman J., 872 Broad av., Ridgefield
Huff, Edmund N., 1635 Bedford rd., San Marino, Cal.
Hull, Donald B., 88 W. Ridgefield av., Ridgewood
Irwin, John H., 51 Tenaflly rd., Englewood
Jacobitti, Edmund E., 491 Maywood av., Maywood
Jenkins, Alvah R., 40 Armory st., Englewood
Johnson, G. Leonard, 390 Booth av., Englewood
Johnston, Rufus O., Parkside rd., Harrington Park
Johnston, Sidney F., 365 Rochelle av., Rochelle Park
Jordan, Walter L., 145 Engle st., Englewood
Jukofsky, Isidore D., 32 Union pl., Ridgefield Park
Kakascik, Emil J., 206 Palisade av., Garfield
Kanning, Fred'k R., 57 W. Allendale av., Allendale
Kastler, Franz, 54 Ames av., Rutherford
Keir, Floyd E., 308 Engle st., Englewood
Kennedy, Paul A., 147 Tenaflly rd., Englewood
King, Chester A., 412 Kinderkamack rd., Oradell
Kingslow, George L., 346 First st., Hackensack
Kissinger, Donald J., 120 E. Madison av., Dumont
Knapp, Richard E., 25 Hudson st., Hackensack
Knight, Wm. T., 515 Oradell av., Oradell
Knowles, George M., 241 Main st., Hackensack
Knox, Charles A., 138 Bergen av., Ridgefield Park
Knox, Harriet L., 390 Union st., Hackensack
Kosminsky, Louis, 30 W. Edsel Blvd., Palisades P'k
Kraissl, Cornelius J., 393 Main st., Hackensack
Lamberto, Vito A., 422 Stuyvesant av., Lyndhurst
Latona, Joseph A., 78 Main st., Lodi
Legato, Samuel F., 417 Palisade av., Cliffside Park
Lemmerz, Willard H., 184 Hackensack st., W'd-Ridge
Lesko, Stephen W., 234 Mt. Pleasant av., Wallington
Levitas, George M., 77 Fairview av., Westwood
Levitas, Irving M., 77 Fairview av., Westwood
Levy, Jack D., 191 Union st., Hackensack
Lewis, Alice B., E. Saddle River rd., Saddle River
Littwin, Chas., 950 Queen Ann rd., Teaneck
Liva, Arcangelo, 5 Pangborn pl., Hackensack
Liva, G. Albin, Madison av., Wyckoff
Liva, Paul F., 280 Stuyvesant av., Lyndhurst
Loman, Sam'l G., 130 Magnolia av., Cresskill
Lombardi, Frank L., 25 E. Clinton av., Bergenfield
Lord, C. Donald, 496 S. Maple av., Glenrock
Luedgecke, Roland E., 216 Randolph av., E. Rutherford
Luria, Sanford A., 249 Queen Anne rd., Bogota
Lynch, Maurice M., 396 Union st., Hackensack
Lyons, Romola L. K., 171 Meadowbr'd rd., Englew'd
Macaulav, Francis A., 815 Elm av., Teaneck
MacKellar, James M., 26 E. Clinton av., Tenaflly
MacLaren, Philip J., 397 Kinderkamack rd., Westwood
Maddren, Russell F., 322 Park st., Hackensack
Mader, A. Ivan, Jr., 430 Union st., Hackensack
Mancene, Edward M., 145 Marshall av., Little Ferry
Magee, Henry R., 55 John st., New York, N. Y.
Markley, Luther A., Holy Name Hosp., Teaneck
Marx, Frederick, 486 Churchill rd., W. Englewood
McCormack, Frank C., 95 Tenaflly rd., Englewood

McFeely, Percy R., 242 Palisade av., Bogota
 McGuire, Joseph T., 77 Autumn st., Lodi
 McLane, A. Donald, 498 Engle st., Englewood
 McLeod, Harry J., 71 Forrest rd., Tenafly
 Mears, William G., 222 Overlook av., Leonia
 Metz, Henry, 5 Pangborn pl., Hackensack
 Meyer, Howard M., 400 Maple Hill dr., Hackensack
 Mockett, Walter W., 714 Palisade av., Grantwood
 Modrys, Walter F., 1400 Palisade plaza, Hudson Hgts.
 Mores, Herbert R., 65 Bergen av., Ridgely Park
 Morrow, Joseph R., Bergen Pines, Oradell
 Mosher, Henry L., 325 Valley Brook av., Lyndhurst
 Muller, Fred'k L., 413 Third st., Carlstadt
 Mulligan, Luke A., 230 Central av., Leonia
 Myers, Norman V., 41 Magnolia av., Tenafly
 Neary, Edward R., 1 W. Harriet av., Palisades Park
 Netz, Lester W., 414 Main st., Hackensack
 Neville, Robert J., 547 Main st., Hackensack
 Nichols, Frank I., 52 Euclid av., Hackensack
 Nicol, Lorenz C., 360 Larch av., Bogota
 O'Brien, Paul, 196 Main st., E. Rutherford
 Olpp, John L., 100 E. Palisade av., Englewood
 Oren, Hyman, Park av., Park Ridge
 Padden, Aloysius F., 408 Main st., Hackensack
 Pagano, Peter, 45 N. Broad st., Ridgewood
 Patti, Frank A., 241 Broad st., Leonia
 Payne, Joseph, 223 Godwin av., Midland Park
 Pedevill, Joseph R., 232 Highland av., Palisades P'k
 Perham, Roy G., 248 Boulevard, Hasbrouck Heights
 Pettit, Harry H., 138 Franklin av., Ridgewood
 Phillips, Walter, 109 E. Palisade av., Englewood
 Pitkin, Geo. P., 4 S. Washington av., Bergenfield
 Placa, James A., 112 Prospect st., Ridgewood
 Policastro, Nelson C., 378 Union st., Hackensack
 Prall, Henry E., 755 Anderson av., Cliffside Park
 Prather, Charles G., 260 Westwood av., Westwood
 Prather, John W., 155 N. Washington av., Dumont
 Protzman, Thomas B., 39 Park pl., Englewood
 Prout, Wm. B., 88 W. Forrest av., W. Englewood
 Pullen, Guy F., 111 Leonia av., Leonia
 Rader-Hoheb, Katherine, 5 Lincoln av., Rutherford
 Reich, Samuel B., 286 Union st., Hackensack
 Reid, Erwin W., 125 Marsellus pl., Garfield
 Reilly, David F., Bergen Pines, Oradell
 Reinhold, H. E., 441 W. Englewood av., W. Englew'd
 Richards, Ernest W., 374 DeWolf pl., Hackensack
 Richardson, Charles A., Main st., Closter
 Ringe, Charles L., Jr., 786 Palisade av., Teaneck
 Ringewald, Robert H., 284 Broad av., Leonia
 Roberts, Charles D., 71 Chestnut st., Englewood
 Robinson, Silas E., Franklin Turnpike, Waldwick
 Romano, Anthony M., 332 Liberty av., Hillsdale
 Rowohlt, George O., 175 Washington av., Dumont
 Rube, Joseph A., 145 Prospect st., Ridgewood
 Ruch, Valentine, 115 W. Palisade av., Englewood
 Rucker, William C., 408 Main st., Hackensack

Ryley, Harold W., 1 Lincoln pl., E. Rutherford
 Sandler, Moses, 2013 Center av., Fort Lee
 Sandler, Samuel A., 70 Anderson st., Hackensack
 Sarafian, Aram M., 131 Market st., W. Englewood
 Sarla, Michael, 55 Hudson st., Hackensack
 Schiro, S. Robert, 73 Main st., Lodi
 Schmidt, Walter W., 386 Palisade av., Cliffside Park
 Schretzmann, Rudolph C., 60 Donaldson av., Ruth'rf'd
 Scillieri, John, 811 E. 22nd st., Paterson
 Scullion, Arthur A., 460 Anderson av., Cliffside P'k
 Sealey, Henry J., 79 S. Washington av., Dumont
 Segard, Christian P., 204 Glenwood av., Leonia
 Seiler, Benjamin, 580 Palisade av., Cliffside Park
 Sexton, Edward V., 936 Queen Anne rd., Teaneck
 Seymour, Edward T., 55 Hillside av., Tenafly
 Skvarla, John A., 17 Koster st., Wallington
 Smaine, Enrique delC., 502 Summit av., Carlstadt
 Smith, Bryan A., 20 West Plaza, Ridgewood
 Smith, Nehemiah E., 33½ Humphrey st., Englewood
 Snedecor, Spencer T., 50 Anderson st., Hackensack
 Solworth, Lee, 100 E. Palisade av., Englewood
 Somers, Willard H., 157 Engle st., Englewood
 Spicola, Louis A., 343 Union st., Lodi
 Spiegelglass, Abraham B., 417 Main st., Hackensack
 Tanner, Monroe J., Paramus
 Taylor, Harold W., 247 Mountain road, Englewood
 Tennis, Edgar M., 375 Engle st., Englewood
 terKuile, Reinold W., 88 W. Ridgew'd av., Ridgew'd
 Tether, Russell K., Main st., Closter
 Toal, Joseph, 803 Prospect av., Ridgely
 Tomlins, Francis I., 11 Oak st., Ridgewood
 Turner, Isabel B., 141 Sheffield av., Englewood
 Tyson, Frances B., 101 Leonia av., Leonia
 Vanderbeek, Stuart W., 143 Engle st., Englewood
 Van Dyke, Jos. S., 42 Palisade Blvd., Palisades P'k
 Vann, Fe'ix H., 201 E. Palisade av., Englewood
 Van Winkle, Charles L., 79 Ridge rd., Rutherford
 Villegas, Juan A., 406 Lafayette av., Cliffside Park
 Vita, Frank J., 595 Palisade av., Cliffside Park
 Vroom, Wm. L., 88 W. Ridgewood av., Ridgewood
 Walsh, Thomas M., 210 Kipp av., Hasbrouck Hgts.
 Warren, Charles B., 181 Prospect av., Bergenfield
 Webb, Wilson D., 316 State st., Hackensack
 White, Frank S., 916 Red rd., Teaneck
 Whitman, Lloyd B., 7 West Clinton av., Bergenfield
 Whittaker, Neil M., 418 Main st., Hackensack
 Widetsky, Alfred, 85 Broadway, E. Paterson
 Williams, William C., 9 Ridge rd., Rutherford
 Willis, Benedict P., 185 Montross av., Rutherford
 Wilson, Harrison B., 430 Union st., Hackensack
 Winter, Gladys C., 717 Norma court, Teaneck
 Witkoff, Ben, 215 Terrace av., Hasbrouck Heights
 Worcester, George F., 220 Engle st., Englewood
 Wry, Orlin V., 95 High st., E. Rutherford
 York, James L., 331 River rd., New Milford
 Zaccino, Arnold A., 1001 Anderson av., Palisade

Number of Active Members and basis of representation, 280, on March 15, 1941.

Transfers

Rowohlt, George O., from Kings County, N. Y.

Tanner, Monroe J., from New Haven County, Conn

BURLINGTON COUNTY (3)

OFFICERS



GEORGE T. TRACY
President
Beverly



E. WARREN RODMAN
Secretary
Beverly



E. VERNON DAVIS
Treasurer
Vincentown



T. BRUCE DICKSON
Reporter
Riverton

Society organized May 19, 1829. Meets second Thursday evening of each month, except June, July and August. Annual Meeting in November.

Active Members

Anderson, Richard D., 465 High st., Burlington
Atkinson, James Q., State Colony, New Lisbon
Betts, R. Winfield, 22 N. Main st., Medford
Bray, William E., 41 Elizabeth st., Pemberton
Busansky, Samuel T., Circle dr., Browns Mills
Conroy, John S., 122 E. Broad st., Burlington
Curtis, Howard C., 224 E. Main st., Moorestown
Darlington, Emlen P., New Lisbon
Davis, E. Vernon, 63 Mill st., Vincentown
Davis, Jacob M., 1400 High st., Burlington
Dickson, T. Bruce, 408 Main st., Riverton
Downs, Roscius I., 40 Scott st., Riverside
Fahrenbruch, Fred'k D., 101 Garden st., Mt. Holly
Frank, Reuben, Hanover & Hampton sts., Pemberton
Geary, Russell D., 337 Bridgeboro rd., Riverside
Haines, Edgar J., Medford
Haldeman, Robert E., Mt. Holly
Hartman, Luther M., 111 E. Main st., Maple Shade
Hogan, Carlton P., 220 E. Union st., Burlington
Hollingshead, Lyman B., Pemberton
Hornberger, J. Howard, Fourth & Main sts., Roebling
Hunter, Edward R., 321 Union av., Delanco
Imhoff, Robert E., 29 E. Main st., Moorestown
Kuder, Joseph M., 104 Garden st., Mt. Holly
Landis, Harry P., Jr., 925 Columbus av., Palmyra
LeFavor, Dean H., 619 Morgan av., Palmyra
Longsdorf, Harold E., Mt. Holly
Love, Elizabeth F., 142 E. Oak av., Moorestown
Lucas, W. Fred, 23 W. Broad st., Burlington
Mark, Harry B., Riverton
McDonnel, Gerald E., 200 Garden st., Mt. Holly
Mendenhall, Clinton D., 412 Farnsw'th av., B'rd'nt'n
Metzer, Emma P. W., 430 Fairview st., Riverside
Metzer, Freeman W., 428 Fairview st., Riverside
Meyer, Eugene A., 407 Chester av., Moorestown
Mills, Charles S., 106 Lippincott av., Riverton
Muldoon, Edward J., 200 3rd st., Florence
Munro, Charles A., Marlton
Newcomb, Marcus W., Browns Mills
Newmeyer, Joseph, 739 Chestnut st., Delanco
Peacock, Arthur B., 39 W. Main st., Columbus
Remer, Daniel F., 417 High st., Mt. Holly
Rodman, E. Warren, 503 Cooper st., Beverly
Rogers, Harry L., 408 Main st., Riverton
Schisler, Milton M., 2nd & Church sts., Florence
Scott, Parry M., 466 Cooper st., Beverly
Shapiro, Charles S., Maple Shade
Shippo, Hammell P., 739 Chestnut st., Delanco
Siddall, John R., 404 Lippincott av., Riverton
Sparks, Paul R., 102 W. Broad st., Burlington
Stokes, Joseph, 220 E. Main st., Moorestown
Stokes, S. Emlen, 129 Chester av., Moorestown
Summey, Thomas J., 800 Golf View rd., Moorestown
Thorne, Nathan, 117 Chester av., Moorestown
Tracy, George T., 222 Warren st., Beverly
Ulmer, D. H. B., 199 Chestnut st., Moorestown
Viteri, Luis E., 214 High st., Mount Holly
Voss, John C., 634 Thomas av., Riverton
Wagner, J. George, Riverbank, Delanco
Wyman, Edward H., 100 E. Broad st., Burlington

Number of Active Members and basis of representation, 60, on March 15, 1941.

Honorary Members

Bauer, Harry W., Palmyra

Wilkinson, George H., Moorestown

Transfer

Newmeyer, Joseph, from Camden County

CAMDEN COUNTY (4)

OFFICERS



ROBERT S. GAMON
President
Camden



GEORGE B. GERMAN
Secretary
Camden



ELLIOTT C. SHULL
Treasurer
Camden



HAROLD D. BARNSHAW
Reporter
Camden

Society organized August 14, 1846. Meets first Tuesday in each month, October to May, inclusive, with an outing in June. Annual Meeting in May.

Active Members

Adams, George B. M., 304 Monmouth st., Gloucester
Anderson, Wm. M., 20 Kings H'way, W., Haddonf'd
Andrus, David L., 805 Cooper st., Camden
Assante, M. Hugo, Evesham av., Magnolia
Athey, Kenneth L., 3616 Westfield av., Camden
Baker, Banks S., 601 Walnut st., Camden
Baker, Maurice E., 1149 Kaighn av., Camden
Barb, Kirk B., 1303 Princess av., Camden
Barnshaw, Harold D., 2626 Federal st., Camden
Barroway, James N., 3064 Federal st., Camden
Becker, C. Frederick, 620 Benson st., Camden
Beideman, Casper M., 5 W. Maple av., Merchantville
Bentley, David F., Jr., 406 Cooper st., Camden
Betancourt, Raul R., 406 Cooper st., Camden
Bowen, Robt. N., Evergr'n & W'dlyne avs., Woodlynne
Braun, William, 4307 W. Maple av., Merchantville
Brennan, Charles L. S., 14 S. Broadway, Gloucester
Brennan, John P., 429 Cooper st., Camden
Brown, Stanley L., Glen av., Laurel Springs
Browning, W. Kempton, 120 N. Centre st., Merchantville
Browning, Wm. J., 134 N. Centre st., Merchantville
Burns, Wilmer F., 267 White Horse Pk., Audubon
Bush, Ralph K., 131 E. Park av., Merchantville
Buzby, B. Franklin, 414 Cooper st., Camden
Carlander, O. R., 1972 Browning rd., Merchantville
Casselmann, Arthur J., 301 N. Second st., Camden
Ciliberti, Frank J., Jr., 5th & Pine sts., Camden
Clark, Ernest W., 209 Haddon av., Westmont
Cohen, Paul, 500 State st., Camden
Collier, Martin H., Camden Co. T.B. Hosp., Lakeland
Coxson, Harold P., Laurel rd., Stratford
Crist, Walter A., 725 Collings av., W. Collingswood
Cunningham, Joel B., 801 Cooper st., Camden
Davis, Albert B., 511 Cooper st., Camden
Davis, J. Stannard, 350 Kings H'way, E., Haddonf'd
Day, Grafton E., Frazer & N. J. avs., Collingswood
Decker, Henry B., 527 Penn st., Camden
Deibert, Irvin E., 538 Cooper st., Camden
Deibert, Kirk R., 159 Elm av., Woodlynne
Del Duca, Vincent P., 527 Cooper st., Camden
Dempsey, J. Harvey, Washington av., Berlin
Denbo, Elic A., 854 Haddon av., Camden
Driscoll, Chas. D., 6 White Horse Pk., Haddon Hgts.
Drossner, Jacob L., 1300 Park Blvd., Camden
Eaton, Arthur T., 201 Fourth av., Haddon Heights
Ebner, Paul G., 719 Cooper st., Camden
Ellis, Alexander, 513 Broadway, Camden
Eynon, Harold K., 579 Haddon av., Collingswood

Eynon, James R., 700 Haddon av., Collingswood
Farrell, Edgar A., 100 Kings Highway W., Haddonf'd
Fessman, John W., Clements Bridge rd., Runnemede
Filkins, Cedric E., 418 White Horse Pike, Audubon
Friedrich, Harry E., 4172 Federal st., Camden
Friedenberg, Sidney, 2990 Alabama rd., Camden
Gamon, Robert S., 527 Cooper st., Camden
Geissler, Elmer E., 327 Monmouth st., Gloucester
German, Geo. B., 429 Cooper st., Camden
Gilson, John A., Jr., 220 8th av., Haddon Heights
Gilbert, Phillip D., Cooper Hospital, Camden
Girardo, Anthony J., 22 Taunton av., Berlin
Glover, Lawrence L., 53 Kings H'way, W., Haddonf'd
Goldman, Samuel, Seventh & State sts., Camden
Goldstein, Hyman I., 1425 Broadway, Camden
Gordon, Milton H., 12 N. 27th st., Camden
Grenhart, Geo. W., 430 Haddon av., Camden
Griffey, Wm. C., 132 Haddon av., Westmont
Griscom, Lee E., 604 Broadway, Camden
Hadley, C. Frazer, 210 W. Maple av., Merchantville
Hadley, C. Frazer, Jr., 21 Haddon av., Westmont
Haines, Mabel C. S., 600 White Horse Pk., Audubon
Hallinger, Earl S., 517 Cooper st., Camden
Hanson, Alfred S., 533 Monmouth st., Gloucester
Haury, Victor G., 206 Cedarcroft av., Audubon
Hays, Roy G., 567 Haddon av., Collingswood
Hemphill, E. H., 232 Kings Highway, E., Haddonfield
Hessert, Edmund C., 417 Cooper st., Camden
Hirst, E. Reed, 634 Federal st., Camden
Hollinshed, Beulah S., 600 Benson st., Camden
Howard, J. Edgar, 67 King's H'way, W., Haddonfield
Hughes, Thomas E., 223 Cooper st., Camden
Hummel, Ernest G., 414 Cooper st., Camden
Hummel, Merwin L., 135 N. Centre st., Merchantville
Husted, Gerald W., 306 Eighth av., Haddon Heights
Ironsides, Paul A., 571 Benson st., Camden
Jack, H. Wesley, 538 Cooper st., Camden
Jackson, Chas. H., 1250 Park Blvd., Camden
Johnson, Herbert F., Cooper Hospital, Camden
Jones, John C., 805 Princeton av., Camden
Judson, G. Vernon, Jr., 316 Ninth av., Haddon Hgts.
Kain, Thomas M., 403 Cooper st., Camden
Kerdasha, Richard F., 538 Cooper st., Camden
Keyser, David, 1518 Baird av., Camden
Kinney, Albert G., 917 Haddon av., Collingswood
Kline, Oram R., 414 Cooper st., Camden
Kutner, Chas., 1005 S. Fifth st., Camden
Larossa, Ernest A., 640 Federal st., Camden

Lee, Thomas B., 622 Cooper st., Camden
 Lewis, Thos. K., 47 S. 27th st., Camden
 London, Russell L., 288 Massachusetts av., Atl. City
 Lovett, Joseph C., Municipal Hospital, Camden
 MacAlpine, Kenneth B., 308 Monm'th st., Gloucester
 Madden, Theophilus W., 16 Frazer av., Collingsw'd
 Magee, Edward S., 604 White Horse Pike, Oaklyn
 Magee, Russell S., 201 White Horse Pike, Audubon
 Mahaffey, J. Lynn, 406 Warwick rd., Haddonfield
 Maldeis, Albertos M. K., 117 N. Sixth st., Camden
 Marcarian, Henry G., 904 Cooper st., Camden
 Marcy, John W., 117 E. Park av., Merchantville
 McCallum, Arthur S., 213 Clem'ts Br. rd., Barrington
 McCarthy, Arthur M., 2772 Federal st., Camden
 McConaghy, Thomas P., 10th & Cooper sts., Camden
 McDermott, Vincent T., 511 State st., Camden
 McGlade, Thomas H., 2953 Yorkship Sq., Camden
 McWilliams, Charles E., Blackwood
 Mecray, Paul M., 405 Cooper st., Camden
 Mecray, Paul, Jr., 405 Cooper st., Camden
 Mengel, Willard G., 400 Penn st., Camden
 Meyer, George P., 410 Haddon av., Camden
 Murray, Edwin N., 558 Newton av., Camden
 Murray, Robert A., 27 East Greenwood av., Oaklyn
 Ornaf, I. Edward, 1145 Thurman st., Camden
 Osmun, Milton M., 611 Broadway, Camden
 Phillips, Claude B., 891 Haddon av., Collingswood
 Pike, Charles E., 411 Newton av., Oaklyn
 Pinsky, Harry A., 944 S. 5th st., Camden
 Platt, Edward V., 221 8th av., Haddon Heights
 Pratt, Arthur G., 516 Cooper st., Camden
 Pratt, William H., 516 Cooper st., Camden
 Price, Henry S., Jr., 3005 Kearsage av., Camden
 Principato, Roberto, 402 Wanlut st., Camden
 Rapp, Robert F., 932 Haddon av., Collingswood
 Read, William T., Jr., 429 Cooper st., Camden
 Rhone, David S., 1202 Haddon av., Camden
 Richardson, Emma M., 581 Stevens st., Camden
 Riegert, Louis C., 475 White Horse Pike, Collingsw'd
 Ristine, Edwin R., 542 Cooper st., Camden
 Roberts, Joseph E., Jr., 403 Cooper st., Camden
 Rossell, Edward W., 801 Cooper st., Camden
 Rudolph, John P., 108 W. Maple av., Merchantville
 Ruttenberg, Max, 303 Cooper st., Camden
 Samter, Max, 4711 Westfield av., Camden
 Santor, G. Frank, 3176 Westfield av., Camden
 Saunders, Orris W., 1700 Broadway, Camden
 Schall, Reuben E., 537 N. Seventh st., Camden
 Scheffler, Wilhelm A. H., 511 Cooper st., Camden
 Schellenger, Edward A. Y., 429 Cooper st., Camden
 Schrack, Helen F., 216 N. Fifth st., Camden
 Schwartz, Henry C., Raritan av., Atco
 Seto, Stanford P. T., Black Horse Pike, Blackwood
 Shafer, Albert H., 405 Cooper st., Camden
 Shafer, F. William, 634 Penn st., Camden
 Sharp, Reuben L., 719 Cooper st., Camden
 Shaw, Ernest B., 811 Collings av., W. Collingswood
 Sheaffer, Clinton P., 241 King's Hghwy., E., Had'n'd
 Shemeley, Wm. G., Jr., 7 Haddon av., Camden
 Sherk, A. Lincoln, 2647 Westfield av., Camden
 Shipman, Jas. S., 542 Cooper st., Camden
 Shope, Edward P., 511 Cooper st., Camden
 Shull, Elliott C., 517 Cooper st., Camden
 Sieber, Isaac G., 204 Merchant st., Audubon
 Smith, Bertram H., 1000 Kings H'way, Haddon Hts.
 Smith, James D., 701 N. Sixth st., Camden
 Smith, Wilbur A., 2 E. Clinton av., Oaklyn
 Snagg, William T., 719 Cooper st., Camden
 Sochacki, Alexander, 1478 Mt. Ephraim av., Camden
 Stein, Joseph M., 956 Newton av., Camden
 Stephenson, Daniel H., 213 Haddon av., Haddonfield
 Stimus, Howard G., 300 Kaighn av., Camden
 Stone, Arthur L., 2838 Berkeley st., Camden
 Stone, Frank P., Laurel rd., Laurel Springs
 Sufrin, Emanuel, 119 N. 27th st., Camden
 Summerill, Garnett, 330 Cooper st., Camden
 Swiecicki, Martin E., 317 Clements Br. rd., Barringt'n
 Tatem, Henry R., Jr., Pine st. & Atlantic av., Audubon
 Thompson, Penrose H., 4612 Westfield av., Camden
 Van Sciver, John E. L., 106 Broadway, Camden
 Warwick, Ralph A., 3300 Federal st., Camden
 Watkins, George R., La Pierre rd., Magnolia
 Waugh, Bascom S., 1882 S. Tenth st., Camden
 Weimann, Max L., 803 Station av., Haddon Heights
 West, David H., 517 Cooper st., Camden
 West, Gordon F., 527 Penn st., Camden
 Wheatland, Marcus F., 727 Walnut st., Camden
 Wilson, Lester R., 3320 Federal st., Camden
 Wright, Ralph S., 428 Richie av., W. Collingswood
 Wroblewski, Benj. M., 1166 Thurman st., Camden

Number of Active Members and basis of representation, 186, on March 15, 1941.

Honorary Members

Day, Grafton, Collingswood
 Marcy, John, Merchantville

Osmun, Milton M., Camden
 Pratt, Arthur G., Camden

Resigned

Lyon, Leslie C., Magnolia

Transfers

Friedenberg, Sidney, from Philadelphia Co., Pa.

Newmeyer, Joseph, to Burlington County

CAPE MAY COUNTY (5)**OFFICERS**

ALDRICH C. CROWE
President
Ocean City



CLARENCE W. WAY
Secretary-Reporter
Sea Isle City



WARREN D. ROBBINS
Treasurer
Cape May

Society organized December 18, 1883. Eight regular meetings each year. Meets on second Tuesday, October to May inclusive. Semi-annual meeting in October. Annual Meeting in May.

Active Members

Bernheisel, Louis E., Reading av., Tuckahoe
Brooks, George M., Cape May Course House
Cameron, C. Paul, 401 Atlantic av., Ocean City
Cohen, Maurice B., Woolworth Bldg., Wildwood
Cooper, Jules, Washington st., Woodbine
Corson, Allen, 824 Wesley av., Ocean City
Crowe, Aldrich C., 735 Atlantic av., Ocean City
Cryder, Millard C., Cape May Court House
Dandois, George F., 220 E. Wildwood av., Wildwood
Darby, C. Eugene, Plymouth pl. & Atl. av., Ocean City
Friedland, Arnold J., Woodbine
Haines, Willits P., 601 Ninth st., Ocean City

Hornstine, Harry H., 4015 Pacific av., Wildwood
Hughes, Frank R., Columbia av. & Oc'n st., Cape May
Hughes, Samuel B., Pine & Pacific avs., Wildwood
Mace, Margaret, 2410 Atlantic av., N. Wildwood
Monosson-Friedland, Ida, Woodbine
Moon, Alexander C., Cape May
Pettit, Herschel, 807 Wesley av., Ocean City
Robbins, Warren D., 202 Ocean av., Cape May
Smith, Marcia V., 821 Wesley av., Ocean City
Steel, William A., Beesley's Point
Townsend, John B., 824 Wesley av., Ocean City
Way, Clarence W., Landis av. & 46th st., Sea Isle City
Whiticar, John H., 717 Wesley av., Ocean City

Number of Active Members and basis of representation, 25, on March 15, 1941.

Resigned

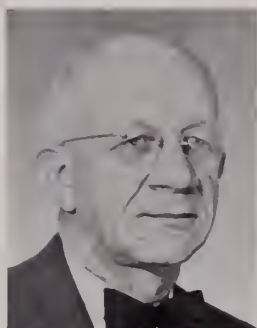
Jennings, Edward C., Washington, D. C.

Transfer

Jonas, August, to Cumberland County

CUMBERLAND COUNTY (6)

OFFICERS



CHARLES BUTCHER
President
Heislerville



F. MURIEL RAMSEY
Secretary
Millville



HERBERT H. WILSON
Treasurer
Bridgeton



EARL C. LYON
Reporter
Bridgeton

Society organized June 16, 1816. Meets on the second Tuesday of October, December, February, April and June. Annual Meeting in April. Special scientific meetings are held in the evening in November, January, March and May.

Active Members

Aitken, Frank J., 119 N. Pearl st., Bridgeton
Bacon, Mary, 278 E. Commerce st., Bridgeton
Baker, Clifford, 8th & Elmer sts., Vineland
Baker, Hugh W., 8th & Elmer sts., Vineland
Bauman, Kenneth R., 213 N. Third av., Millville
Bellak, Ellis R., Leesburg
Bennett, Samuel D., 118 Pine st., Millville
Berkowitz, Benjamin, 188 E. Commerce st., Bridgeton
Bostwick, Delazon S., Hotel Cumberland, Bridgeton
Branin, Howard S., 200 W. Main st., Millville
Butcher, Charles, Heislerville
Cornwell, Alfred, 265 N. Laurel st., Bridgeton
Corson, Kenneth E., 25 S. Myrtle st., Vineland
Cunningham, Charles, 7th & Wood sts., Vineland
Davies, George A., 53 Front st., Elmer
Day, Samuel T., Main st., Port Norris
DeSantis, Orazio J., 100 N. Second st., Millville
Garrison, W. Sherman, Main st., Cedarville
Giacalone, Vincent, 649 Landis av., Vineland
Gray, Charles M., 6th & Grape sts., Vineland
Jonas, August, 117 Broad st., Bridgeton
Kauffmann, Louis J., 228 N. Second st., Millville
Knowles, James S., 316 N. Second st., Millville
Kratka, William H., 123 N. Pearl st., Bridgeton
Kump, Albert B., 31 W. Commerce st., Bridgeton
Lihn, Barney, 611 Elmer st., Vineland
Loder, Horace B., 225 E. Commerce st., Bridgeton
Lore, Harry E., Main st., Cedarville
Lyon, Earl C., 194 E. Commerce st., Bridgeton
Magolda, Anthony F., 727 Grape st., Vineland
Marchione, Nicholas E., 109 S. Seventh st., Vineland

Mayhew, Charles H., 329 Pine st., Millville
Mezzetti, Alfred F., 220 S. Sixth st., Vineland
Miller, H. Garrett, 203 E. Main st., Millville
Myatt, Leslie E., 98 N. Pearl st., Bridgeton
Neal, Charles B., Pine & Third sts., Millville
Nitshe, George A., Jr., 100 S. Main st., Elmer
Pino, Anthony, 196 Irving av., Bridgeton
Ramsey, F. Muriel, 310 E. Pine st., Millville
Reeves, J. Franklin, 55 East av., Bridgeton
Rosen, Sol, 214 N. Second st., Millville
Rosenthal, Bernice D., E. Landis av., Vineland
Sewall, Millard F., 195 E. Commerce st., Bridgeton
Sharp, Charles E., Main st., Port Norris
Sheppard, A. G., 309 Broad st., Elmer
Sheppard, Frank R., 131 N. Third st., Millville
Sheppard, Muse A., Penn & Broad sts., Elmer
Shirlock, Margaret E., Training School, Vineland
Siegel, Sidney L., 227 N. Second st., Millville
Thalheimer, Edward J., 7th & Plum sts., Vineland
Thomas, George N., 712 Wood st., Vineland
Van Deusen, Edwin H., 12 N. Seventh st., Vineland
Walker, Ada H., 635 Landis av., Vineland
Walker, H. Burton, 635 Landis av., Vineland
Ware, Carl N., Bridgeton rd., Shiloh
Ware, F. Vernon, 223 N. Second st., Millville
Weithaase, Helen E., 8th & Elmer sts., Vineland
Whaland, Berta, 117 Atlantic st., Bridgeton
Wilson, Charles W., 636 Wood st., Vineland
Wilson, Herbert H., 24 Bank st., Bridgeton
Winslow, John H., 27 S. Valley av., Vineland
Woodruff, Dare, 630 Landis av., Vineland

Number of Active Members and basis of representation, 62, on March 15, 1941.

Honorary Members

Elmer, Matthew K., Bridgeton
Simpkins, Raymond, Bridgeton
Wainwright, Frederick P., Bridgeton

Transfers

Jonas, August, from Cape May County
Siegel, Sidney, from Hudson County

ESSEX COUNTY (7)

OFFICERS



HARRY N. COMANDO
President
Newark



MARCUS H. GREIFINGER
Secretary
Newark



ROBERT H. ROGERS
Treasurer
Newark



PAUL H. HOSP
Reporter
Newark

Society organized June 4, 1816. Meets second Thursday of each month, October to May, inclusive. Annual Meeting is second Thursday in May.

Active Members

- Abel, Arthur R., 144 Harrison st., East Orange
 Abrams, Abram B., 299 Clinton av., Newark
 Adelman, Benjamin B., 190 Clinton av., Newark
 Agnew, Hobart M., 17 Plymouth st., Montclair
 Albano, Edwin H., 242 Clifton av., Newark
 Albano, Frank J., 535 North 7th st., Newark
 Albano, Joseph, 535 North 7th st., Newark
 Alcamo, John H., 215 Littleton av., Newark
 Alexander, Walter G., 48 Webster pl., Orange
 Alford, Ralph I., 83 Park st., Montclair
 Allan, James S., 144 Harrison st., East Orange
 Allen, Chester B., Jr., 254 Midland av., Montclair
 Allen, G. Herbert, 181 Roseville av., Newark
 Allen, Raymond N., 144 Harrison st., East Orange
 Alling, Frederic A., 15 Washington st., Newark
 Altman, Charles D., 301 Highland av., Newark
 Ambrose, Anthony, 71 Congress st., Newark
 Anderson, Robert C., 686 Mt. Prospect av., Newark
 Anderson, William A., 1255 Broad st., Bloomfield
 Antonius, Nicholas A., 27 W. Market st., Newark
 Antopol, William A., 201 Lyons av., Newark
 Anuario, Charles B., 365 S. Centre st., Orange
 Applebaum, Irving L., 31 Lincoln Park, Newark
 Areson, Wm. H., 153 Bellevue av., Upper Montclair
 Arons, Harry, 717 High st., Newark
 Ash, Samuel, 25 Johnson av., Newark
 Asher, Maurice, 186 Clinton av., Newark
 Aszody, Paul, 340 Waverly av., Newark
 Bachmann, Wm., 87 Hillcrest ter., East Orange
 Bacote, Ernest F., 78 Barclay st., Newark
 Bagg, Linus W., 31 Lincoln Park, Newark
 Baiocchi, Pascal J., 203 Hunterdon st., Newark
 Baird, Thompson N., 1625 32nd st., S. St. Peter's b'g, Fla.
 Baker, Charles F., 198 Clinton av., Newark
 Baker, Maelyn F., 638 Stuyvesant av., Irvington
 Baldwin, Samuel H., 626 Clinton av., Newark
 Balson, Zachary D. B., 49 Osborne ter., Newark
 Barkhorn, Charles W., 223 Roseville av., Newark
 Barkhorn, Henry C., 45 Johnson av., Newark
 Barnard, Frank G., 22 Plymouth st., Montclair
 Barrett, John E., 635 Summer av., Newark
 Barrett, Jos. F., 230 Parker av., Maplewood
 Baum, Felix, 10 Elm court, South Orange
 Baum, Samuel, 10 Osborne ter., Newark
 Bauman, Everett O., 17 Hillside av., Newark
 Bauman, Rush C., 92 High st., Nutley
 Becker, Frederick W., 14 Clinton pl., Newark
 Becker, Martin, 94 So. Munn av., East Orange
 Becket, George C., 350 Springdale av., East Orange
 Beling, C. Abbott, 111 Clinton av., Newark
 Beling, Christopher C., 111 Clinton av., Newark
 Bell, Horace O., Essex Co. Isolation Hosp., Belleville
 Bennett, Wm. F., Essex Mt. Sanatorium, Verona
 Berardinelli, Carmine G., 92 Eighth av., Newark
 Berg, Samuel, 156 Roseville av., Newark
 Berger, Wm. A., 346 Roseville av., Newark
 Bergman, Meyer W., 31 Lincoln Park, Newark
 Berman, H. Robert, 286 Roseville av., Newark
 Bernhard, Wm. G., 142 Clinton av., Newark
 Bernson, Samuel T., 653 So. 18th st., Newark
 Bernstein, Arthur, 668 Clinton av., Newark
 Besson, Franklin J., 999 Clinton av., Irvington
 Bianchi, Angelo R., 184 Hunterdon st., Newark
 Bien, Frank A., 999 Clinton av., Irvington
 Bigelow, Elizabeth F., 120 Prospect st., So. Orange
 Bigelow, Nelson S., 120 Prospect st., South Orange
 Bingham, Arthur W., 144 Harrison st., East Orange
 Birdsall, Clarence A., 9 Smull av., Caldwell
 Bissett, John V., 29 Hawthorne av., East Orange
 Blackburne, George, 490 Central av., Newark
 Blanchard, Kenneth, 25 S. Munn av., East Orange
 Blaustein, Maurice L., 37 Hillside av., Newark
 Bleiberg, Jacob, 31 Lincoln Park, Newark
 Bleick, Theodore E., 61 Van Ness pl., Newark
 Block, Marcus T., 177 Bloomfield av., Newark
 Block, Max, 48 N. Fullerton av., Montclair
 Block, Milton, 711 Chancellor av., Irvington
 Bocchini, Jos. A., 366 S. 12th st., Newark
 Borsher, Irving P., 249 Broad st., Bloomfield
 Bove, Joseph, 306 Lincoln av., Orange
 Brackett, Elizabeth R., 371 Franklin av., Nutley
 Bradford, Stella S., 16 Seymour st., Montclair
 Bradshaw, John H., 27 High st., Orange
 Brakeley, Elizabeth, 71 Myrtle av., Montclair
 Brandman, Otto, 83 Johnson av., Newark
 Braun, Gustav A., 221 S. Orange av., Newark
 Breitstadt, Charles A., 563 Summer av., Newark
 Brien, William M., 449 Main st., Orange
 Briggs, Henry, 144 Harrison st., East Orange
 Brim, Anne S., Hotel Edgemere, East Orange
 Broadnax, Mary E., 140 Roseville av., Newark
 Brodtkin, Eva T., 365 Osborne ter., Newark
 Brotman, Morton M., 90 Avon av., Newark
 Brown, Chester R., 22 Midland av., Arlington

- Brown, Chester T., Prudential Ins. Co., Newark
Brown, Edward V., 9 Park av., Caldwell
Brown, Lewis W., 160 Roseville av., Newark
Brown, Richard J., 105 Ridgewood rd., So. Orange
Bruning, Richard H., 372 Wyoming av., Maplewood
Buckley, Jeremiah L., 666 Franklin av., Nutley
Budington, Walter I., 24 Commerce st., Newark
Bugbee, Frederick C., 802 E. Fifth st., Tucson, Ariz.
Bull, Louis M., 92 Heller Parkway, Newark
Bull, Robert I., 361 Lafayette st., Newark
Bull, William J., 98 Park st., Montclair
Burke, Leonard P., 39 Lakeside av., Verona
Burke, Stephen E., 212 First av., Newark
Burne, John J., 17 Gould av., Newark
Burpeau, Wm. P., 1538 E. W. H'w'y. Silver Spring, Md.
Burrill, Benjamin B., Jr., 303 Montgomery st., Blm'fd
Burstein, Frank, 402 Clinton av., Newark
Busch, Herman, 38 Johnson av., Newark
Bush, Archer C., 40 Union st., Montclair
Butler, Eustace C., 249 Bloomfield av., Caldwell
Buvinger, Chas. W., 50 Washington st., East Orange
Byck, Louis, 794 South 11th st., Newark
Bythewood, Alton E., Jr., 145 W. Market st., Newark
Cacciarelli, Robert A., 517 Roseville av., Newark
Caggiano, Anthony P., 237 Grove st., Montclair
Cahill, Laurence A., 361 Lafayette st., Newark
Caldwell, Donald M., Prudential Ins. Co., Newark
Calvert, Wm. C., 225 Gregory av., West Orange
Camche, Leo J., 250 Renner av., Newark
Cameron, Arthur E., 59 Somerset st., Newark
Cameron, Edwin A., 186 S. Burnett st., East Orange
Campbell, Wm., 144 Harrison st., East Orange
Caputo, Anthony R., 217 Belleville av., Belleville
Carbone, Francesco N., 440 Central av., Orange
Cardwell, Edgar P., 47 Central av., Newark
Carlisle, Paul E., 763 Broad st., Newark
Carman, Fletcher F., 31 Lincoln Park, Newark
Carpenter, Charles A., 10 N. Ridgewood rd., S. Orange
Carrigan, Francis P., 305 Roseville av., Newark
Carrol, Wilfred, 51 Ingraham pl., Newark
Casale, John B., 359 Bloomfield av., Newark
Castellano, Martin G., Essex Mountain Sana, Verona
Cater, Douglas A., 57 So. Harrison st., East Orange
Cerone, Daniel M., 309 First av., Newark
Cestone, Canio, 521 Pompton av., Cedar Grove
Cetrulo, Gerald I., 234 Mt. Prospect av., Newark
Chamberlain, Aims R., 30 Lenox pl., Maplewood
Chamberlain, Richard R., 30 Lenox pl., Maplewood
Champlin, Paul M., 43 S. Arlington av., E. Orange
Chapman, Robt. W., Ward Hmstd., Boyden av., Mplwd.
Charbonneau, Eugene G., 111 S. Harrison st., E. Or.
Cherashore, Harry N., 363 Centre st., Nutley
Chiger, Alexander S., 621 High st., Newark
Chimacoff, Hyman, 171 Elizabeth av., Newark
Chmelnik, Abraham G., 299 Clinton av., Newark
Christian, Albion C., 1080 Clinton av., Irvington
Clark, J. Henry, 108 Orange rd., Montclair
Clarcken, Jos. A., 30 Van Ness pl., Newark
Claus, C. Hermann, 776 S. 19th st., Newark
Clement, Baxter L., 31 Lincoln Park, Newark
Coburn, J. Wesley, 111 N. Oraton Pkwy., E. Orange
Coe, Richard, 156 Clinton av., Newark
Coffin, Henry F., 116 N. Ninth st., Newark
Coughlan, Jasper, 540 Parker st., Newark
Cohen, I. Elvin, 561 Elizabeth av., Newark
Cohen, Maurice, 106 Valley rd., Montclair
Cohen, Max, 60 Ridge rd., North Arlington
Cohen, Meyer J., 118 Johnson av., Newark
Cohen, Sidney A., 283 Clinton pl., Newark
Cohen, Sidney L., 20 Avon av., Newark
Cohen, Sidney P., 512 Franklin av., Nutley
Cohn, George M., 748 So. 10th st., Newark
Cohn, Hermann, 393 Clinton av., Newark
Cohn, Royal M., 740 Clinton av., Newark
Coleman, Russell M., 54 N. Clinton st., East Orange
Colmer, M. Jonas, 31 Lincoln Park, Newark
Colsh, LeRoy L., 612 Ridgewood rd., Maplewood
Colton, Ethan T., Jr., 31 Park st., Montclair
Comando, Harry N., 690 Clinton av., Newark
Connamacher, Harold S., 671 Springfield av., Newark
Connolly, John J., 180 Ballantine Pkwy., Newark
Connolly, Richard N., 117 Fifth st., Newark
Cook, Hugh F., 21 Roseville av., Newark
Cooke, William H., 303 Main st., East Orange
Cooperman, Wm., 647 Market st., Newark
Cordasco, Peter, 24 Dodd st., Bloomfield
Cornish, Charles H., 673 Prospect st., Maplewood
Coughlan, Ella A., 10 Oakwood av., Orange
Coughlin, Frank J., 100 Magnolia av., Arlington
Cox, John C., 55 Woodland rd., Maplewood
Cox, William W., 79 S. Fullerton av., Montclair
Crane, Charles G., 78 Farley av., Newark
Crapanzano, Domenico, Essex Co. Hosp., Cedar Grove
Crawford, Georgina U., 28 Carnegie av., E. Orange
Crecca, Anthony D., 76 Second st., Newark
Crecca, William D., 111 Park av., Newark
Cregar, John S., 150 Harrison st., East Orange
Crossfield, Henry C., 144 Harrison st., East Orange
Crystell, Edward H., 4 Hawthorne av., Nutley
Curtis, Elbert A., 65 Central av., Newark
D'Agostini, Alfred J., 41 Columbia av., Newark
D'Alessandro, Arthur J., 15 Salem st., Newark
D'Ambola, Philip R., 21 S. Sixth st., Harrison
Dane, Charles, 61 Scotland rd., South Orange
Dane, John, 61 Scotland rd., South Orange
D'Angelo, Joseph C., 330 Washington av., Belleville
Danzis, Maximillian, 31 Lincoln Park, Newark
Darden, Walter T., 149 W. Kinney st., Newark
Daron, Simeon, 31 Lincoln Park, Newark
Davenport, Peter B., 764 S. Orange av., Newark
Davidson, Henry A., 31 Lincoln Park, Newark
Davidson, Louis L., 31 Lincoln Park, Newark
Davies, Geo. W., 35 Fairview av., Verona
Davis, Louis, 825 S. Tenth st., Newark
Davis, Thomas C., 30 Old Short Hills rd., Millburn
DeFronzo, Morando, 180 Fairmount av., Newark
Deignan, Wm. L., 257 Dodd st., East Orange
Del Deo, Nicholas V., 49 State st., Newark
Del Guercio, Olindo, 365 Bloomfield av., Newark
Denes, Oscar, 402 Centre st., Nutley
DePalma, Anthony F., 226 Roseville av., Newark
DePhillips, Benedict R., 43 Park av., Newark
DeTroia, Frederick C., 40 12th av., Newark
Deutel, Oscar R., 283 Franklin st., Bloomfield
De Vincentis, Henry, 285 Henry st., Orange
DeVivo, John A., 225 Littleton av., Newark
Devlin, Hugh J., 72 Thomas st., Newark
Dias, Joseph L., 17 Lombardy st., Newark
Dieffenbach, Richard H., 570 Mt. Prospect av., Newark
DiFino, Felix J., 88 Jefferson st., Newark
DiGiacomo, Harry E., 2 Prospect pl., Newark
DiGiacomo, Wm. H., 223 Fairmount av., Newark
Dinge, Ferdinand C., 67 S. Munn av., East Orange
DiNoccia, Joseph, 498 West Market st., Newark
Dodd, Edward L., 157 Forest st., Belleville
Donahue, Wm. J., 71 S. Ninth st., Newark
Donchi, Sol M., 9 Madison av., Newark
Dorn, Elliott I., 267 Vassar av., Newark
Dowd, Ambrose F., 239 Broadway, Newark
Dragonetti, Elvige N., 177 Clifton av., Newark
Dranow, Paul, 233 Franklin av., Nutley
Drapkin, Berta, 31 Lincoln Park, Newark
Dreskin, Jacob L., 172 Lyons av., Newark
DuBois, Morris G., 769 High st., Newark
Dulin, Everett V., 144 Harrison st., East Orange
Dunn, Theodore B., 35 Park pl., Bloomfield
Durchlag, E. Nelson, 12 Myrtle av., Irvington
Eagleton, Wells P., 15 Lombardy st., Newark
Ebenfeld, Samuel W., 344 High st., Newark
Echikson, Joseph I., 31 Lincoln Park, Newark

- Edelen, James J., 280 So. Clinton st., East Orange
 Ehrlich, Edward, 79 Shanley av., Newark
 Ehrlich, William E., 31 Lincoln Park, Newark
 Eichler, Bernard B., 221 Midland av., Montclair
 Eigen, Louis A., 511 Valley rd., West Orange
 Ein, William B., 31 Lincoln Park, Newark
 Eisenberg, David S., 31 Lincoln Park, Newark
 Ellis, Arthur J., 282 Broad st., Newark
 Ellis, Moury I., 177 So. Clinton st., East Orange
 Emerson, Linn, 303 Park av., Orange
 Emmer, S. Wolfe, 31 Lincoln Park, Newark
 English, John T., 110 Yale av., Irvington
 Epler, Don A., 45 Hillside av., Newark
 Epstein, Harry B., 31 Lincoln Park, Newark
 Erler, Eugene W., 360 Irving av., South Orange
 Ervin, Millard B., 572 Prospect st., Maplewood
 Etheridge, Chas. H., 433 Prospect st., East Orange
 Evans, Chas. H., 144 Harrison st., East Orange
 Evans, David P., 144 Harrison st., East Orange
 Ewing, Harvey M., 31 Trinity pl., Montclair
 Fader, Ferdinand, 3 So. Grove st., East Orange
 Fager, Rudolph O., 53 Park pl., Bloomfield
 Failing, Brayton E., 31 Lincoln Park, Newark
 Fanburg, Sol J., 31 Lincoln Park, Newark
 Farden, Joseph L., 342 Roseville av., Newark
 Farkas, Morris, 163 High st., West Orange
 Farr, Irving L., 214 Walnut st., Montclair
 Faughnan, Rose C., 97 High st., Passaic
 Fechner, Julius, 362 Clinton av., Newark
 Fein, Bernard S., 585 Elizabeth av., Newark
 Feldman, Frank H., 115 Lyons av., Newark
 Fendrick, Edward, 17 Watson av., East Orange
 Feneck, Chas. C., University Hosp., Ann Arbor, Mich.
 Ferguson, Wm. E., 22 James st., Newark
 Fern, Samuel S., 122 Elizabeth av., Newark
 Feuer, Joseph A., 654 Elm st., Arlington
 Fewsmith, Joseph L., 120 Second av., Newark
 Filippone, Ames L., 149 Clifton av., Newark
 Fine, M. James, 65 Girard pl., Newark
 Fink, Irving E., 129 Lyons av., Newark
 Finkel, Joshua, 368 Clinton av., Newark
 Finkelstein, Abe S., 670 Clinton av., Newark
 Finkler, Rita S., 35 Leslie st., Newark
 Finnerty, Urban R., 71 Park st., Montclair
 Fischer, David D., 356 Millburn av., Millburn
 Fischman, Harold H., 326 Avon av., Newark
 Fissell, George M., 530 Orange st., Newark
 Fitzpatrick, Edw. F., 546 W. Market st., Newark
 Flanagan, John J., 173 Roseville av., Newark
 Fleischmann, Viola G., 341 16th av., Irvington
 Fleming, Joseph A., 247 Claremont av., Montclair
 Flower, Morrie A., 39 Lincoln Park, Newark
 Flynn, Edward A., 161 Washington av., Belleville
 Foley, James F., 331 N. Grove st., East Orange
 Ford, Theodore R., 144 Harrison st., East Orange
 Forsyth, Kenneth C., 130 MacLaren st., Ottawa, Can.
 Fort, J. Irving, 306 Roseville av., Newark
 Forte, Daniel L., 545 Central av., Orange
 Forte, Frank S., 318 Roseville av., Newark
 Fortunato, Samuel J., 345 Walnut st., Newark
 Foster, William H., 107 Franklin st., Belleville
 Foster, Herbert W., 2 Erwin Park, Montclair
 Foster, William S., 233 Mt. Prospect av., Newark
 Fowler, Royale H., 744 Broad st., Newark
 Franklin, Frank A., 304 Central av., Orange
 Freeman, George C., Prudential Ins. Co., Newark
 Freinkel, Jacob, 2 Hillside av., Newark
 Friedman, Harry, 721 S. 16th st., Newark
 Friedman, Hyman, 1096 Sanford av., Irvington
 Friedman, Milton, 31 Lincoln Park, Newark
 Froelich, Joseph C., 74 Ingraham pl., Newark
 Furman, Benj. A., 31 Roseville av., Newark
 Furst, Nathan J., 299 Clinton av., Newark
 Galioto, Frank M., 188 Ampere Pkwy., Bloomfield
 Gamba, Jos., 345 Fairmount av., Newark
 Ganley, Arthur J., 390 Park av., East Orange
 Ganot, Frank I., 392 Ridge st., Newark
 Gardam, Joseph W., 16 Longfellow av., Newark
 Gardner, Kenneth E., 45 Fremont st., Bloomfield
 Gauch, William, 177 Elwood av., Newark
 Geller, Samuel, 784 High st., Newark
 Gencher, Benjamin, 24 Ravine av., Caldwell
 Gennell, Ernest, 298 Parker st., Newark
 George, Melbourne E. W., 744 Broad st., Newark
 Gerard, Patrick D., 364 Roseville av., Newark
 Gershenfeld, David B., 20 Hillside av., Newark
 Glannetti, Ernest D., 14 Harrison av., Montclair
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 Gifford, William R., 247 Park av., East Orange
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 Gluckman, Saul K., 78 Johnson av., Newark
 Godfrey, Alan O., 231 Roseville av., Newark
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 Goldberg, Louis E., 31 Lincoln Park, Newark
 Goldberg, Samuel A., 169 Gregory av., West Orange
 Goldberg, Samuel M., 353 Washington av., Belleville
 Golden, Clement H., 347 16th av., Irvington
 Goldman, Lester M., 896 So. 16th st., Newark
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 Goldstein, Wm. H., 632 Belgrove dr., Arlington
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 Grady, Wm. F., 42 N. Fullerton av., Montclair
 Graham, Richard B., 575 Belgrove dr., Arlington
 Granberry, D. Webb, 136 S. Main st., Orange
 Grant, William F., 309 Roseville av., Newark
 Gray, John W., 142 Clinton av., Newark
 Greenberg, Samuel, 46 Johnson av., Newark
 Greenfield, Bernard H., 691 Clinton av., Newark
 Greenfield, Leonard S., 691 Clinton av., Newark
 Greenwald, Theo. L., 44 Maple av., Morristown
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 Gregorius, Ralph F., 120 Irvington av., So. Orange
 Gregory, Mildred G., 64 N. 9th st., Newark
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 Griffin, Guy B., 197 S. Centre st., Orange
 Griffith, Roy, 909 Broad st., Newark
 Gross, Isadore, 60 Lakeside av., Verona
 Grossblatt, Philip, 67 Baldwin av., Newark
 Grubin, Harold, 22 Treacy av., Newark
 Grunt, Louis, 35 Shanley av., Newark
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 Hahn, William H., 15 Lombardy st., Newark
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Hawkes, E. Zeh, 84 Washington st., Newark
Hawkes, Stuart Z., 84 Washington st., Newark
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Heineken, Theodore S., 17 Park pl., Bloomfield
Heller, Abraham R., 10 Kearny av., Kearny
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Henle, Carye-Belle, 671 Springfield av., Newark
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Herndon, Lewis S., 144 S. Harrison st., East Orange
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Hewson, George F., 21 Roseville av., Newark
Hexamer, Fred, 50 Lyons av., Newark
Heyman, Arthur, 79 Baldwin av., Newark
Higi, Joseph E., 31 Lincoln Park, Newark
Hill, James O., 84 Barclay st., Newark
Hill, Robert H., 339 Parker st., Newark
Hirschberg, Samuel, 615 High st., Newark
Hobart, Richard T., 454 Park st., Upper Montclair
Holler, Henry G., 234 Montclair av., Newark
Holmes, George J., 17 Elizabeth av., Newark
Holtz, Harry M., 56 Johnson av., Newark
Hooton, Thomas C., 31 Trinity pl., Montclair
Horn, Harry, 622 Stuyvesant av., Irvington
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Hubbard, Robert Y., 942 Sanford av., Irvington
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Humphries, Robert E., 637 Central av., East Orange
Hurff, J. Wallace, 86 Washington st., Newark
Husserl, Siegfried, 777 Clinton av., Newark
Hymowitz, Ben, 66 Baldwin av., Newark
Ill, Carl H., 188 Clinton av., Newark
Ill, Edgar A., 1004 Broad st., Newark
Ill, Edmund W., 188 Clinton av., Newark
Ill, Edward J., 1004 Broad st., Newark
Ill, Herbert M., 188 Clinton av., Newark
Inge, Hutchins F., 205 So. Orange av., Newark
Inge, Theodore R., 336 Halsted st., East Orange
Irwin, James R., 330 Washington av., Belleville
Isaac, Benoit C., 227 Main st., Orange
Israeloff, Howard H., 1038 Clinton av., Irvington
Jackson, Albert F., 225 Hillside av., Nutley
Jackson, George H., 2092 Morris av., Union
James, Bart M., 31 Lincoln Park, Newark
James, William L., 31 Lincoln Park, Newark
Janifer, Clarence S., 208 Parker st., Newark
Jaso, James V., 710 Varsity rd., South Orange
Jedel, Meyer, 125 4th st., Newark
Jennings, Robt. E., 143 Park st., East Orange
Jessurun, Samuel H., 613 High st., Newark
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Judge, John F., 33 Hazelwood av., Newark
Kaderabek, Erwin J., 144 S. Harrison st., E. Orange
Kahrs, Grace M., 140 Roseville av., Newark
Kalb, Samuel W., 416 Clinton pl., Newark
Kalter, George E., 640 Prospect st., Maplewood
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Kaufman, Jerome G., 299 Clinton av., Newark
Kaufman, Michael J., 103 Lyons av., Newark
Kavanaugh, Daniel E., 566 Mt. Prospect av., Newark
Kearney, Edward P. J., 83 S. Fullerton av., Montcl'r
Kearney, John F., 228 Hilton av., Maplewood
Keim, William F., 25 Roseville av., Newark
Keith, Theodore R., 656 Bloomfield av., Nutley
Keller, Paul, 564 N. Edgemere dr., W. Allenhurst
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Kessler, Henry B., 666 Clinton av., Newark
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Kirkby, Cyril S., 45 Woodland av., Glen Ridge
Kirkman, Leroy G., 176 Roseville av., Newark
Klein, Andrew J. V., 209 Littleton av., Newark
Klein, Edward C., Jr., 209 Littleton av., Newark
Kleinberger, Harry H., 59 Main st., Millburn
Kleinman, Maurice, 101 Clinton av., Newark
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Kline, George L., 310 Mt. Prospect av., Newark
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Kraemer, Manfred, 31 Lincoln Park, Newark
Kraker, David A., 31 Lincoln Park, Newark
Kralik, Joseph J., 555 Market st., Newark
Krichbaum, Carroll E., 63 Myrtle av., Montclair
Krone, William F., 31 Lincoln Park, Newark
Kruger, William, 31 Lincoln Park, Newark
Kummel, Max, 31 Lincoln Park, Newark
Lafferty, Elton B., 330 Myrtle av., Irvington
Landesman, William, 187 Kearny av., Kearny
Lane, Austin W., 98 Prospect st., East Orange
Leaman, Granville M., 167 N. Grove st., E. Orange
Le Bel, Louis J. B., 165 Grant av., Nutley
Leber, Otto H., 56 Church st., Montclair
Lee, John J., 309 Park av., Orange
Lee, Stephen G., 55 Halsted st., East Orange
Lemkin, Samuel, 71 Pomona av., Newark
Leonardis, James V., 94 Jefferson st., Newark
Levin, Joseph, 831 South 13th st., Newark
Levine, Edward P., 86 Clinton av., Newark
Levine, Philip, Beth Israel Hospital, Newark
Levinson, Louis J., 18 Stratford pl., Newark
Levinson, Robert M., 859 S. 13th st., Newark
Levison, William, 75 Lincoln Park, Newark
Levitt, Jesse N., 26 Clinton pl., Newark
Levy, Anna L., 260 Meeker av., Newark
Levy, Julius, 19 Lyons av., Newark
Lewandowski, Edmund E., 665 Grove st., Irvington
Lewis, G. Rae, 458 Washington av., Belleville
Lewis, Leon, 190 Clinton av., Newark
Liccese, Emanuel, 84 Jefferson st., Newark
Licks, Fred'k C., 117 Irvington av., South Orange
Lieb, Saul, 337 Hawthorne av., Newark
Lifland, Bernard D., 35 Shanley av., Newark
Lilien, Bernard B., 730 Lyons av., Irvington
Lincoln, Jennings S., 140 Watchung av., Up.M'tcl'r
Lipstein, William, 845 Chancellor av., Irvington
Livingston, Paul, 299 Main st., East Orange
Loder, Joseph S., 924 S. 17th st., Newark
Loeser, Lewis H., 31 Lincoln Park, Newark
Lottridge, Dorothy, 43 S. Maple av., East Orange
Lovell, Frederick H., 1013 Clinton av., Irvington
Lovell, John F., 1011 Clinton av., Irvington
Lowenstein, Aaron, 860 South 11th st., Newark
Lowenstein, Harry A., 96 Milford av., Newark
Lowrey, James H., 79 Congress st., Newark
Lowy, Otto, 190 Clinton av., Newark
Luban, Benjamin, 730 High st., Newark

- Lundblad, Walter E., 75 Prospect st., East Orange
 Luongo, Federico, 212 S. Centre st., Orange
 Lurie, Solomon I., 21 Hillside av., Newark
 Lutz, Wolf, 493 Watchung av., Bloomfield
 Lutz, William M., 3 Southern Slope dr., Millburn
 Lyon, Archibald, 115 Ridge rd., No. Arlington
 Lyons, James V., 333 Park av., Orange
 Maas, Max A., 329 Clinton av., Newark
 Mabey, J. Corwin, 242 Claremont av., Montclair
 Macaluso, Dominic C., 7 Hilton st., Belleville
 MacArt, James H., 74 S. Munn av., East Orange
 MacArthur, Clymont, 219 Roseville av., Newark
 MacDonald, Wentworth S., 56 Church st., Montclair
 Maciejewski, Anthony S., 212 Van Buren st., Newark
 MacMillan, Wright, 4 Duryea rd., Upper Montclair
 Macpherson, Elwood H., 34 Rawley pl., Millburn
 Maggio, George A., 110 Fleming av., Newark
 Magovern, Thomas F., 228 S. Orange av., S. Orange
 Mahood, Herbert L., 86 Durand rd., Maplewood
 Mamlot, Alfred M., 16 Johnson av., Newark
 Mancusi-Ungaro, Elviro, 268 Mt. Prospect av., Newark
 Mancusi-Ungaro, Lodovico, 156 Mt. Prospect av., Newark
 Marcus, Donald, 640 Stuyvesant av., Irvington
 Margolis, Alfred, 218 West End av., Newark
 Margulies, Charles, 188 High st., Nutley
 Marks, Edward G., 655 Kearny av., Arlington
 Marks, Zelda I., 95 Wilson av., Newark
 Marquis, Dean W., 144 Harrison st., East Orange
 Marquis, W. James, 198 Clinton av., Newark
 Marra, Rocco S., 221 Park av., Orange
 Martin, Wm. P., 25 Holland rd., South Orange
 Martland, Harrison S., Newark City Hosp., Newark
 Mason, Virgil A., 144 Harrison st., East Orange
 Massengill, Fulton, 802 Livingston rd., Elizabeth
 Masterson, John F., 98 Myrtle av., Irvington
 Matheke, George A., 592 Park av., East Orange
 Matheke, Otto G., 328 Sussex av., Newark
 Matheke, Otto G., Jr., 328 Sussex av., Newark
 Matheson, Gilchrist E., 144 S. Harrison st., East Orange
 Matthews, Clifford B., 1180 Raymond Blvd., Newark
 Matthews, Harry E., 504 Hillside av., Orange
 Matthews, Wm. F., 61 S. Fullerton av., Montclair
 Maurer, K. Virginia, 26 W. Northfield av., Livingston
 May, Ernst A., 157 Harrison st., East Orange
 McBride, Hesser G., 1972 S. Orange av., Newark
 McCarroll, E. Mae, 59 Hillside pl., Newark
 McCauley, Francis J., 31 Lincoln Park, Newark
 McCormick, Jas. E., 775 Elizabeth av., Newark
 McCroskery, Jas. H., 396 N. Arlington av., East Orange
 McCullough, Walter A., Essex Co. Hosp., Cedar Gr.
 McGuire, John J., 2 Gould av., Newark
 McKim, William F., 317 Roseville av., Newark
 McLellan, Geo. A., 19 Hawthorne av., East Orange
 McVay, Edward A., 234 Lafayette st., Newark
 Medd, John C., 25 Curtis pl., Maplewood
 Meehan, Martin M., 339 Washington av., Belleville
 Meeker, Irving A., 581 Valley rd., Upper Montclair
 Mellen, Stanley H., Livingston Bldg., Livingston
 Menk, Paul E., 31 Lincoln Park, Newark
 Merkelbach, Walter P., 288 Broad st., Bloomfield
 Merliss, Eugene, 386 Clinton av., Newark
 Merselis, John G., 110 Irvington av., South Orange
 Meurlin, Alfred, 158 S. Harrison st., East Orange
 Mierau, Ernest W., 1096 Sanford av., Irvington
 Miller, Herman P., 815 S. 12th st., Newark
 Miller, I. Irwin, 675 Sanford av., Newark
 Miller, Joseph A., 364 Prospect st., South Orange
 Miller, Nathan, 861 Lyons av., Irvington
 Minard, Edwy L., 140 4th av., East Orange
 Minier, Carl L., 153 Mt. Pleasant av., West Orange
 Miningham, Wm. D., 18 Hedden ter., Newark
 Minnefor, Charles A., 1164 S. Orange av., S. Orange
 Mishell, Daniel R., 31 Lincoln Park, Newark
 Mitchell, Augustus J., 59 South st., Newark
 Moeckel, Clarence W., 63 S. Fullerton av., Montclair
 Mohrbacher, John J., 37 Osborne ter., Newark
 Monaco, Saverio A., 293 Camden st., Newark
 Moore, Dean C., 138 N. Arlington av., East Orange
 Mores, Edward J., 1524 Maple av., Hillside
 Moretti, John J., 576 S. Clinton st., East Orange
 Morgan, Browne, 32 Benson st., Bloomfield
 Morris, Clement, 513 Broadway, Newark
 Morrison, Caldwell, 379 7th av., Newark
 Moschkowitz, Hermann, 737 High st., Newark
 Moss, Mary C., 5 Mountain av., Maplewood
 Motzenbecker, Peter F., 680 High st., Newark
 Motzenbecker, William J., 16 Milford av., Newark
 Mount, Walter B., 21 Plymouth st., Montclair
 Muller, Joseph H., 867 South 13th st., Newark
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 Mullin, Raymond J., 76 Shanley av., Newark
 Murray, Harold A., 624 Mt. Prospect av., Newark
 Muta, Samuel A., 47 Park av., West Orange
 Nacca, Carl A., 86 N. Essex av., Orange
 Nadel, Charles I., 1186 Clinton av., Irvington
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 Nappi, Pasquale E., 250 Mt. Prospect av., Newark
 Nash, Alexander E., 30 Forrest av., Verona
 Nash, Herman S., 865 S. 11th st., Newark
 Nash, William G., 20 Clinton st., Newark
 Nataro, Joseph, 172 Littleton av., Newark
 Nemzek, Wm. P. B., 141 Ridge rd., N. Arlington
 Nevius, William B., 610 Park av., East Orange
 Newman, Grace T., 339 Grove st., Montclair
 Newman, Julius, 31 Lincoln Park, Newark
 Ney, J. Marshall, 671 Broad st., Newark
 Nicola, Toufick, 96 Gates av., Montclair
 Noll, Louis, 1383 Clinton av., Irvington
 Norris, Henry M., 21 Sterling drive, South Orange
 Nussbaum, Harvey E., 89 Ferry st., Newark
 Nyiri, William A., 863 S. 12th st., Newark
 Oberlander, Gertrude, 135 Johnson av., Newark
 O'Connor, Bernard A., 47 Central av., Newark
 O'Connor, Dennis F., 671 Broad st., Newark
 O'Connor, Michael J., 98 Shanley av., Newark
 O'Connor, Paul A., 157 Roseville av., Newark
 O'Crowley, Clarence R., 31 Lincoln Park, Newark
 Offenkranz, Frederick M., 72 Hansbury av., Newark
 O'Grady, Michael J., 228 Franklin av., Nutley
 Oleynick, Simeon A., 31 Lincoln Park, Newark
 O'ini, Joseph J., 30 W. Market st., Newark
 O'Neill, Charles L., 11 N. 7th st., Newark
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 Openchowski, Mieczyslaw, 83 Johnson av., Newark
 Orloff, Samuel, 149 Lyons av., Newark
 Orris, Harold J., 1463 Maple av., Hillside
 Orton, Henry B., 224 Delavan av., Newark
 Ostrowski, Sigismund J., 265 Broad st., Bloomfield
 Paddock, Royce, 965 Broad st., Newark
 Palmer, Gideon H., 28 Winans st., East Orange
 Palmer, Henry S., 275 Mulberry st., Newark
 Panitch, William, 90 Baldwin av., Newark
 Pannullo, John N. P., 266 Van Buren st., Newark
 Parell, George C., 275 South 7th st., Newark
 Parent, Sol, 51 Baldwin av., Newark
 Parisi, Anthony, 296 S. Orange av., Newark
 Parker, John E., 144 Harrison st., East Orange
 Parkes, Morey, 33 Park av., Caldwell
 Parsonnet, Aaron E., 3 Madison av., Newark
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Pizzi, Mario V., 205 Park av., Orange
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Probst, Everett W., 176 Carmita av., Rutherford
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Quad, Clifford W., 52 Northfield av., West Orange
Quinby, Wm. O., 14 James st., Newark
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Ragione, Mario D., 277 Clifton av., Newark
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Reich, Mortimer, 31 Lincoln Park, Newark
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Reilly, John V., 520 Sanford av., Newark
Reinhardt, Warren I., 276 Springdale av., E. Orange
Reissman, Erwin, 31 Lincoln Park, Newark
Reitter, George S., 191 Halsted st., East Orange
Renzulli, Francesco, 228 South 7th st., Newark
RePass, Paul E., 85 Harrison st., East Orange
Resch, Henry U., 27 Park pl., Bloomfield
Restaino, Charles F., 1 Garside av., Newark
Rettig, Isidor L., 36 Milford av., Newark
Ribbans, Robert C., 63 Central av., Newark
Rich, Charles, 191 Littleton av., Newark
Rich, Wallace E., Essex Co. Hosp., Cedar Grove
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Robbins, Eugene, 909 Broad st., Newark
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Roberts, Frank A., 11 Park av., Caldwell
Roberts, William A., 11 Park av., Caldwell
Robertson, Euston S., 22 Harding ter., Kearny
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Rocco, Frank, 729 Summer av., Newark
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Rogers, Richard M., 129 S. Munn av., East Orange

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Rosenberg, Max, 23 Wyndmoor av., Hillside
Rosenthal, Arnold J., 263 Clinton pl., Newark
Rosenthal, Sydney, 95 Wilson av., Newark
Rossi, Bartolomeo, 64 Lloyd pl., Belleville
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Rothhouse, Burnet, 31 Lincoln Park, Newark
Rothschild, Daniel L., 585 Elizabeth av., Newark
Rothseid, Abraham, 59 Avon av., Newark
Rubin, Abraham A., 77 S. Munn av., East Orange
Rubino, Nicholas M., 67 N. 4th st., Newark
Rubinow, Saul M., 755 High st., Newark
Runyan, William J., 102 Broad st., Bloomfield
Russomanno, Raymond L., 227 Clifton av., Newark
Rutberg, Ralph H., 23 Johnson av., Newark
Samson, Norman D., 281 Kearny av., Kearny
Santora, Philip J., 361 Roseville av., Newark
Saslow, Benjamin I., 680 Clinton av., Newark
Sasso, Albert, 99 Parker st., Newark
Savel, Lewis E., 872 S. 16th st., Newark
Sax, Max T., 84 Grove st., Bloomfield
Sbarra, Francesco C. N., 189 Roseville av., Newark
Schaaf, Royal A., 413 Mt. Prospect av., Newark
Schaefer, Eugene P., 12 Harrison pl., Irvington
Schaffer, Barney, 252 Washington av., Belleville
Schechtman, Vera, 385 Osborne ter., Newark
Scheller, George A., 701 Clinton av., Newark
Scher, Maurice A., 137 Lyons av., Newark
Schiffmann, Samuel, 107 Spruce st., Newark
Schiller, Nicholas, 29 Girard pl., Newark
Schneider, Charles A., 694 Clinton av., Newark
Schneider, Louis, 874 S. 13th st., Newark
Schotland, Clement E., 41 Leslie st., Newark
Schramm, Joseph A., 572 High st., Newark
Schreck, Harry, 192 Roseville av., Newark
Schulsinger, Samuel, 80 Clinton av., Newark
Schulte, Herbert A., 701 Clinton av., Newark
Schults, Anna R., 207 Summer av., Newark
Schurman, Francis H. C., 14 Smull av., Caldwell
Scott, R. Hunter, 205 Roseville av., Newark
Scranton, Chas. W., 59 Washington st., E. Orange
Seudder, Frank D., 65 N. Fullerton av., Montclair
Seidler, Victor B., 16 Plymouth st., Montclair
Seidman, Edwin A., 580 High st., Newark
Seidman, Joshua I., 31 Lincoln Park, Newark
Seifert, Edwin A., 415 Ridgewood av., Glen Ridge
Sellitto, Anthony M., 268 Valley st., S. Orange
Selvaggi, Carlo, 82 Congress st., Newark
Seward, Wm. H., Orange Memorial Hosp., Orange
Shack, David N., 712 Clinton av., Newark
Shack, Maxwell H., 19 Lyons av., Newark
Shaner, Ralph D., 94 Hillside av., Nutley
Shannon, James B., 66 S. Fullerton av., Montclair
Shannon, Lardner M., 66 S. Fullerton av., Montclair
Shapiro, Louis, 146 Broad st., Newark
Shaul, Frederick G., 10 Washington st., Bloomfield
Shaul, John F., 10 Washington st., Bloomfield
Shaw, John J., 127 Scheerer av., Newark
Sheehan, Daniel C., 535 Sanford av., Newark
Sherman, A. Russell, 671 Broad st., Newark
Sherman, Arthur E., 144 S. Harrison st., E. Orange
Sherman, Elbert S., 671 Broad st., Newark
Shill, Benjamin, 738 High st., Newark
Shlionsky, Herman, Essex Co. Hosp., Cedar Grove
Shor, David M., 32 S. Munn av., East Orange
Shreehan, Hubert F., 620 Summer av., Newark

- Shulman, Murray W., 913 S. 20th st., Newark
 Siegel, Jack G., 38 Johnson av., Newark
 Siegel, Jacob W., 96 S. 10th st., Newark
 Silver, Harry B., 190 Clinton av., Newark
 Silverstein, Benj. J., 32 Hillside av., Newark
 Silverstein, Jacob M., 73 Main st., Millburn
 Simmons, Albert V., 720 Prospect st., Maplewood
 Simms, George F., 541 Page av., Lyndhurst
 Simon, Henry, 5 Vermont av., Newark
 Simon, Ludwig L., 201 Ferry st., Newark
 Simonson, Louis, 202 Osborne ter., Newark
 Singer, Max., 147 Johnson av., Newark
 Sisson, Nelson W., 144 Harrison st., East Orange
 Skwirsky, Joseph, 170 Hawthorne av., Newark
 Slavin, Paul, 31 Lincoln Park, Newark
 Smalley, Sara D., 530 Clifton av., Newark
 Smalzried, Elmer W., 69 Woodland av., E. Orange
 Smith, Byron J., P. O. Box 754, Newark
 Smith, Christopher A., 295 Montgomery st., Bl'mf'd
 Smith, Ellis L., Essex Co. Isolation Hosp., Belleville
 Smith, George H., 136 Evergreen pl., East Orange
 Smith, Harold W., 179 Lincoln av., Orange
 Smith, Henry G., Essex Co. Hosp., Cedar Grove
 Smith, Joseph J., 325 13th av., Newark
 Smith, Leonard A., 32 Washington st., E. Orange
 Smith, Thayer A., Forest dr., Short Hills
 Snavelly, Earl H., Newark City Hospital, Newark
 Sobin, Julius, 24 Waverly av., Newark
 Solk, Arthur G., 88 Clinton av., Newark
 Somers, Fred L., 144 Harrison st., East Orange
 Sorett, Joseph, 530 Central av., Newark
 Sorock, Emil M., 1 Grumman av., Newark
 Soschin, Samuel J., 31 Lincoln Park, Newark
 Spallone, Joseph C., 123 Mt. Prospect av., Newark
 Spinner, Samuel L., 190 Clinton av., Newark
 Sprague, Edward W., 86 Washington st., Newark
 Staehle, Richard H., 34 Lyons av., Newark
 Stahl, Alfred, 55 Lincoln Park, Newark
 Stahl, Charles, 659 Sanford av., Newark
 Statman, Arthur J., 17 Leslie st., Newark
 Steiner, Edwin, 31 Lincoln Park, Newark
 Stevens, Merton H., 58 South Maple av., E. Orange
 Stewart, Robert G., 79 Midland av., Montclair
 Stickles, Lloyd C., 49 Parkhurst st., Newark
 Stiles, C. Campbell, 713 Park av., East Orange
 Stokes, Earle B., 144 Harrison st., East Orange
 Strack, Vincent J., 1072 S. Orange av., Newark
 Strasser, Hans A., 226 N. Park st., East Orange
 Straub, Herbert H., 242 Springdale av., E. Orange
 Straus, Max, 87 Harrison pl., Irvington
 Strauss, Frederick, 845 S. 12th st., Newark
 Strauss, Max, 190 Clinton av., Newark
 Streen, Morris E., 908 Bergen st., Newark
 Sturchio, Edoardo, 104 Ferry st., Newark
 Sturchio, Eugenio, 178 Mt. Prospect av., Newark
 Sullivan, William T., 35 De Witt av., Belleville
 Sutton, Harold L., 777 High st., Newark
 Sutton, Jos. G., Essex Co. Hosp., Cedar Grove
 Swain, Richard D., Jr., 211 Roseville av., Newark
 Symes, Earl R., 161 Kearny av., Kearny
 Szerlip, Leopold, 31 Lincoln Park, Newark
 Tansey, Wm. A., 98 Dover st., Newark
 Tarbell, Harold A., 13 Pennington st., Newark
 Taylor, G. Herbert, 144 Harrison st., East Orange
 Teeter, Charles E., 418 Orange st., Newark
 Tenney, Albert S., 164 S. Harrison st., East Orange
 Thomas, John H., 270 Lenox av., South Orange
 Thomison, Harry E., 605 Broad st., Newark
 Thompson, Arthur F., 144 Harrison st., East Orange
 Thompson, Austin B., 479 Highland av., Orange
 Thomson, Carroll S., Fair Oaks Sanatorium, Summit
 Thornhill, Arthur C., 47 Forest st., Montclair
 Tillis, Herman H., 11 Bergen st., Newark
 Tirrell, C. Malcolm, 71 Lincoln Park, Newark
 Tobey, Franklin J., 11 Hazelwood av., Newark
 Tomec, Richard F., 42 Melrose pl., Montclair
 Torppey, John J., 472 Sanford av., Newark
 Tovey, John E., 90 Midland av., Arlington
 Trautwein, Charles F., 131 Nesbit ter., Irvington
 Turi, Amedeo E., 57 Garside st., Newark
 Turner, Charles F., 151 Grove st., Montclair
 Tushnet, Leonard, 662 18th av., Irvington
 Tutschulte, Ernest, 111 Mt. Pleasant av., Newark
 Twitchell, Adelbert B., 162 S. Orange av., S. Orange
 Tymeson, Walter R., 310 Main st., Orange
 Ulan, Oscar, 170 Fleming av., Newark
 Ulvestad, Lawrence E., 147 Halsted st., E. Orange
 Urbach, George, 187 Chancellor av., Newark
 Vallario, Frank A., 333 Clifton av., Newark
 Vander Veer, H. Garrett, 295 Montgomery st., Bl'mf'd
 Van Emburgh, Geo. H., 575 Belgrove dr., Arlington
 Van Gieson, Edward J., 70 Watsessing av., Bloomf'd
 Vannatta, Geo. W., 226 N. Park st., East Orange
 Van Ness, H. Roy, 444 Parker st., Newark
 Verbeck, George B., 20 Church av., Ballston Spa, N.Y.
 Vincent, Nicholas F., 144 S. Harrison st., E. Orange
 Virgilio, Anthony A., 87 S. Centre st., Orange
 VonHofe, Frederick H., 75 Prospect st., E. Orange
 Voorhees, Florence E., 140 Roseville av., Newark
 Vreeland, Ralph D., 400 Highland ter., Orange
 Wagner, John, 127 Wilson av., Newark
 Wakeley, Wm. E., 144 Harrison st., East Orange
 Waldron, Robert E., 1194 Broad st., Bloomfield
 Wallhauser, Henry J. F., Penn-Stroud, Str'dsb'g, Pa.
 Walsh, Charles R., 21 W. Mt. Pleasant av., Liv'g'stn
 Walton, Ralph W., 102 Gates av., Montclair
 Wambsganss, Magdalene, 44 Devine st., Newark
 Wagner, William F., 102 Broad st., Bloomfield
 Ward, Elisabeth B., 112 Chancellor av., Newark
 Ward, Gertrude P., 41 Park pl., Bloomfield
 Ward, Wm. R., 112 Chancellor av., Newark
 Ward, William R., Jr., 112 Chancellor av., Newark
 Warner, Wm. H. A., 444 Central av., East Orange
 Waterman, Samuel M., 364 C'inton av., Newark
 Wayne, David M., Box 410, Redfield, So. Dakota
 Weber, Francis C., 286 Mt. Prospect av., Newark
 Weeks, Norman E., 470 Grove st., Up. Montclair
 Weimann, Max. H., 714 Scotland rd., Orange
 Weinstein, Francis S., 189 16th av., Newark
 Weinstein, Morris W., 643 Chancellor av., Irvington
 Weinstock, Michael B., 13 Hillside av., Newark
 Weiss, Louis, 519 Springfield av., Newark
 Weiss, Selma, 2 Stratford pl., Newark
 Weller, Arthur, 19 Hillyer st., Orange
 Weston, Clifford G., 27 Woodland av., Glen Ridge
 Wheeler, Wm. K., 31 Lincoln Park, Newark
 Whelan, Edward P., 460 Frank'lin av., Nutley
 Wherry, Elmer G., 325 Clinton av., Newark
 White, Robert R., 25 S. Munn av., East Orange
 Willan, Edward H., 74 S. Munn av., East Orange
 Willey, F. Parker, 153 Roseville av., Newark
 Williams, John J., 88 Walnut st., Newark
 Willis, Katharen C., 31 Trinity pl., Montclair
 Willner, Irving, 18 Waverly av., Newark
 Willner, Philip, 105 Clinton av., Newark
 Willson, James H., 144 Harrison st., East Orange
 Wilson, John H., Jr., 85 Halsted st., East Orange
 Wolf, Raymond E., 281 Park st., Upper Montclair
 Wolfe, Jacob S., 44 Watsessing av., Bloomfield
 Wolfe, William W., 383 Mulberry st., Newark
 Wood, E. LeRoy, 160 Roseville av., Newark
 Woolf, Bernhardt H., 15 Hedden ter., Newark
 Wort, Frederick J., 1080 Broad st., Newark
 Wrensch, Alexander E., 79 Valley rd., Montclair
 Wright, Robert E., 173 Park av., East Orange
 Wurts, Margaret M., 189 Alexander av., Up. Montcl'r
 Wurzel, Milton, 295 Hunterdon st., Newark
 Wyatt, Joseph H., 135 Clinton av., Newark
 Wyker, Arthur W., 57 Park pl., Bloomfield
 Yadkowski, Emanuel, 637 High st., Newark

Yaguda, Asher, 88 Clinton av., Newark
Yates, Glen L., 270 Ridgewood av., Glen Ridge
Ylvisaker, Lauritz S., 763 Broad st., Newark
Zager, Saul, 454 Hawthorne av., Newark
Zehnder, A. Charles, 188 Roseville av., Newark
Zybulewski, Edmund A., 410 Bergen st., Newark

Zimmer, William, 1 Hillside av., Newark
Zimmerman, Coler, 52 N. Arlington av., E. Orange
Zingali, John A., 55 Grove st., Montclair
Zweibel, Leonard, 871 South 11th st., Newark
Zweig, Isidore, 22 Monticello av., Newark

Number of Active Members and basis of representation, 1,005, on March 15, 1941.

Associate Members

Adelman, Nathan, 208 Renner av., Newark
Andermann, Eugenie, 68 E. 86th st., New York City
Baime, Jules E., 41 Renner av., Newark
Balsamo, Joseph J., 314 Bergen st., Newark
Barbella, Joseph D., 498 North 13th st., Newark
Bender, Louis, 284 Ridgewood av., Newark
Binder, Charles I., 173 Lafayette st., Newark
Butan, Louis, 579 Valley rd., West Orange
Cantalupo, Enidio, 95 Nichols st., Newark
Cantelmo, Alphonse L., 207 S. Harrison st., E. Orange
Christoph, Francis T., 10 N. Ridgew'd rd., S. Orange
Conti, Horace, 229 Kearny av., Kearny
Covino, Louis L., 44 Oakland ter., Newark
Dailey, Edward S., 485 Park av., Orange
D'Amico, Thomas V., 16 Grove av., Verona
DeGerome, James H., 10 Ridgewood av., Glen Ridge
DeHart, George K., 132 Sunset av., Verona
Dessauer, Joseph, 80 Clinton av., Newark
Duffy, Edward P., Jr., 330 Washington av., Belleville
Erdman, George L., 142 Clinton av., Newark
Feinsod, Samuel M., 1305 Clinton av., Irvington
Fischbein, Martin M., 817 Chancellor av., Irvington
Frame, Dorothy L., 395 Franklin st., Bloomfield
Gorten, Manfred L., 669 Elizabeth av., Newark
Greenberg, Mortimer, 1463 Maple av., Hillside
Haschec, Walter, 690 S. 19th st., Newark
Hirsch, Theodore, 842 S. 13th st., Newark
Johnson, Robert A., 5 Bloomfield av., Belleville
Kaplan, Henry L., 24 Johnson av., Newark
Kosterlitz, Henry H., 1144 Clinton av., Irvington
Kunz, Harold G., 82 W. Passaic av., Bloomfield
Kuperman, Henry L., 25 Van Velsor pl., Newark
Larkey, Irving G., 95 Shanley av., Newark
Levin, Murray, 96 Washington st., West Orange
Lomhoff, Irving I., Essex Mt. Sanatorium, Verona

Maggio, Nicholas A., 130 Fleming av., Newark
Maisel, Irving, Ordnance Depot, Savanna, Illinois
Masciocchi, Thomas A., 316 Park av., Orange
Mitchell, Walter L., Jr., 195 Roseville av., Newark
Moore, James A., 99 S. Mountain av., Montclair
Oransky, Marvin, 534 S. 11th st., Newark
Ort, Franz J., 160 N. Day st., Orange
Pellicciari, Donald, 29 S. Munn av., East Orange
Quinn, Edward D., 323 Belleville av., Bloomfield
Rigeron, D. George, 160 Franklin st., Bloomfield
Rommer, Jack J., 25 Ingraham pl., Newark
Rosenthal, Oscar J., 666 Clinton av., Newark
Rost, Adolf S., 357 Lincoln av., Orange
Rozsa, Stephen, 811 S. 18th st., Newark
Saracino, Frank J., 124 Grand pl., Arlington
Schwartz, Mortimer L., 450 Belmont av., Newark
Silberner, Herbert B., 104 Hillside av., Newark
Silverman, S. Andrew, 556 15th av., Newark
Solomon, Harold, 249 Avon av., Newark
Sonnenberg, Arthur, Essex Mt. Sanatorium, Verona
Steiner, Herbert, 650 Stuyvesant av., Irvington
Stoli, George F., 330 Washington av., Belleville
Strauss, Leo M., 18 S. Munn av., East Orange
Tansey, Wm. A., Jr., 54 Baltusrol way, Short Hills
Thornley, Wm. F., 11 Ridgewood ter., Maplewood
Toczek, Heinrich A., 404 Bergen st., Newark
Tunis, Benno B., 5 Farley av., Newark
Tutela, Arthur C., 220 S. 7th st., Newark
Valentin, Irmgard, 131 S. Harrison st., E. Orange
Weinberg, Alfred, 654 Lyons av., Irvington
Wesson, Harrison R., 15 The Crescent, Montclair
Wiener, David, 196 Weequahic av., Newark
Winter, Egon W., 825 S. 10th st., Newark
Wuerthele, Virginia E., 311 Mt. Prospect av., Newark
Yablonsky, Max, 171 Osborne ter., Newark
Yoskalka, Jack S., 107th Med. Reg., C'p Livingston, La.

Resigned

Doremus, Widmer E., Mirror Lake, N. H.

Roles, Earl W., East Orange

Transfers

Burrill, Benjamin B., Jr., from Passaic County
Finesilver, Edward M., to New York County
Kralik, Joseph J., from Union County

Harman, Byron M., from Hunterdon County
Harris, Morris, from Morris County

GLOUCESTER COUNTY (8)

OFFICERS



HENRY B. DIVERTY
President
Woodbury



CHESTER I. ULMER
Secretary
Gibbstown



DON B. WEEMS
Treasurer
Wenonah



CLARENCE A. BOWERSOX
Reporter
Woodbury

Society organized December, 1818. Regular meetings on third Thursday of each month, except June, July and August. Annual Meeting in May. Annual Social Session in October.

Active Members

Barrows, Victor I., 316 N. Broadway, Pitman
Black, Maskell B., 139 E. High st., Glassboro
Booth, George R., 219 Highland av., Westville
Bowersox, Clarence A., 509 N. Broad st., Woodbury
Broselow, Benjamin G., Delsea dr., Franklinville
Burkett, J. Paul, 215 Delaware st., Woodbury
Burkett, Wendell J., 16 W. Holly av., Pitman
Campo, A. Guy, 200 Broadway, Westville
Carpenter, Wm. H., 39 Aberdcen pl., Woodbury
Chalfant, Wm. P., Broadway & Crafton av., Pitman
Collins, Louis K., 54 State st., Glassboro
Crain, William E., 64 Cooper st., Woodbury
DiMarino, Anthony J., 735 Delaware st., Paulsboro
Diverty, Henry B., 38 Cooper st., Woodbury
Faux, Frederick J., 171 W. Center st., Woodbury
Fisler, Charles F., 140 Maple st., Clayton
Fooder, Horace M., 110 Main st., Williamstown
Gairdner, Thos. M., 319 W. Broad st., Gibbstown
Gillis, Alfred E., 19 Maple st., Clayton
Harris, William G., Main st., Mullica Hill
Hollinshead, Ralph K., 351 Broadway, Westville
Hughes, Joseph F., 116 N. Broad st., Woodbury
Hunter, Harold H., 114 W. Broad st., Paulsboro
Lintz, Sidney Z., 447 Kings Highway, Swedesboro
Livengood, Baxter A., 64 Cooper st., Woodbury

Moore, Ralph L., 127 N. Broad st., Woodbury
Nelson, Harry, 36 Lupton av., Woodbury
Patterson, Isaac N., 230 Broadway, Westville
Pedrick, William W., 11 West st., Glassboro
Pegau, Paul M., 246 Briar Hill lane, Woodbury
Rhoads, S. Creadick, 104 Station av., Westville
Rogers, Dorothy M., 50 Cooper st., Woodbury
Ruttenberg, Louis, 18 Hopkins st., Woodbury
Serri, William S., N. Main st., Mullica Hill
Sheets, Cecil C., 213 W. Broad st., Paulsboro
Sherman, Fuller G., 204 Delaware st., Woodbury
Sinexon, Henry L., 36 W. Broad st., Paulsboro
Sirota, E. Bernard, 220 W. Broad st., Paulsboro
Sooy, L. Thomas, 202 W. Holly av., Pitman
Stewart, Irving J., 529 Kings Highway, Swedesboro
Thompson, Thomas M., 102 Pitman av., Pitman
Ulmer, Chester I., 431 W. Broad st., Gibbstown
Underwood, J. Harris 509 N. Broad st., Woodbury
Venturo, Ralph C., 101 S. Main st., Glassboro
Wandall, Frederick G., 50 E. High st., Clayton
Weems, Don B., 105 E. Mantua av., Wenonah
Wentzell, J. Earl, 5 E. Mantua av., Wenonah
Whitaker, Henry J., 10 S. Broadway, Pitman
Wood, Oran A., 128 W. Broad st., Paulsboro
Wright, Herman W., 818 S. Broadway, Pitman
Zapf, Reville D., 100 W. Mantua av., Wenonah

Number of Active Members and basis of representation, 51, on March 15, 1941.

Transfer

Lintz, Sidney Z., from Philadelphia County, Pa.

HUDSON COUNTY (9)

OFFICERS



GEORGE GINSBERG
President
Hoboken



THOMAS MCG. BRENNOCK
Secretary
Jersey City



HENRY SPENCE
Treasurer
Jersey City



JOHN N. CONNELL
Reporter
Jersey City

Society organized October 11, 1851. Meets first Tuesday evening of each month, October to May, inclusive. If a legal holiday, meeting to be held on next day. Annual Meeting in May.

Active Members

Adler, Joseph, 933 Ave. C, Bayonne
Africano, Julius V., 2700 Hudson Blvd., Union City
Agolia, Michael W., 441 Palisade av., Union City
Ainsley, H. Bryson, 246 Union st., Jersey City
Allen, Isaac L., 521 Palisade av., Union City
Alpert, Edward, 661 Jersey av., Jersey City
Alter, Nicholas M., 410 Fairmount av., Jersey City
Amdur, Louis A., 2540 Boulevard, Jersey City
Anrig, Grace E., 133 Summit av., Union City
Arbeit, Sidney R., 2521 Boulevard, Jersey City
Aria, Michael H., 31 Glenwood av., Jersey City
Arlitz, William J., 107 Newark st., Hoboken
Arndt, Frank R., 7500 Bergenline av., N. Bergen
Aronowitz, Harry T., 932 Ave. C, Bayonne
Artaserse, Geo. V., 185 Bergen av., Jersey City
Ash, Arthur F., 710 Boulevard E., Weehawken
Atwell, David R., 920 Hudson st., Hoboken
Auriemma, Michele, 419 Adams st., Hoboken
Axford, W. Homer, Chester
Bahuson, Conrad M., 170 Bowers st., Jersey City
Bailyn, Emanuel, 331 16th st., West New York
Ballinger, Reeve L., 659 Kearny av., Arlington
Balsamo, Anthony J., 212 52nd st., West New York
Barbarito, Wm. N., 135 Bentley av., Jersey City
Barishaw, Samuel B., 5 Bentley av., Jersey City
Behrens, Herman H. E., 312 Webster av., Jersey City
Ben-Asher, Solomon, 260 Bergen av., Jersey City
Benjamin, Harold C., 59 Crescent av., Jersey City
Bergmeyer, Josef T., 422 64th st., West New York
Berlin, Joseph I., 2600 Hudson Blvd., Jersey City
Bigliani, Urban R., 606 80th st., North Bergen
Bitten, Robert M., 33 Romaine av., Jersey City
Blakey, Abram P., 155 Wegman Pkwy., Jersey City
Boland, Lucy E., 27 Washington av., Arlington
Bonauno, Peter J., 500 79th st., North Bergen
Bookrajian, Edw. N., 8027 Hudson Blvd., N. Bergen
Borrone, Milton G., 2695 Boulevard, Jersey City
Borshaw, Hyman, 108 Bentley av., Jersey City
Bortone, Frank, 2765 Hudson Blvd., Jersey City
Bosselli, Emile H., 614 15th st., Union City
Botti, John A., 236 Summit av., Jersey City
Boyle, Francis L., 829 Boulevard, Bayonne
Bradasch, George A., 1415 Central av., Union City
Brady, Thomas S., 678 Ave. C, Bayonne
Brady, William A., 412 44th st., Union City
Braitman, Max, 412 60th st., West New York
Branch, W. Harold, 190 Duncan av., Jersey City

Brandenburg, Leo W., 2802 Hudson Blvd., Union City
Brauer, Selig L., 234 Bergen av., Jersey City
Braunstein, Sigmund C., 424 13th st., W. New York
Braunstein, Wm. P., 1 Bellevue st., Weehawken
Brennock, Thos. McG., 3 Webster av., Jersey City
Brick, George J., 43 Cottage st., Jersey City
Brophy, Francis X., 55 Gifford av., Jersey City
Brozdowski, John J., 54½ Jersey av., Jersey City
Butler, Vincent P., 33 Bentley av., Jersey City
Callery, William T., 10 Columbia ter., Weehawken
Cannon, Edward A., 7512 Hudson Blvd., N. Bergen
Caridi, Salvatore, 5135 Bergenline av., W. New York
Carr, Mary B., 1 Astor pl., Jersey City
Cassidy, John M., 1913 Hudson Blvd., Jersey City
Chapman, Ellis J., 203 Danforth av., Jersey City
Chayes, Sydney, 980 Ave. C, Bayonne
Cieri, Daniel S., 1515 Central av., Union City
Clark, Chas. C., 461 New York av., Union City
Cohen, Herman, 489 Jersey av., Jersey City
Cohen, Herman N., 714 Park av., Hoboken
Cohen, Samuel, 343 Fairmount av., Jersey City
Cohen, Samuel A., 477 Jersey av., Jersey City
Comora, Herman C., 317 60th st., West New York
Connell, Emmet J., 2227 Hudson Blvd., Jersey City
Connell, John N., 26 Carlton av., Jersey City
Connolly, Thomas W., 921 Bergen av., Jersey City
Conty, Anthony J., 318 48th st., Union City
Cosgrove, Samuel A., 254 Union st., Jersey City
Coughlin, John P., 160 Wegman Pkwy., Jersey City
Cracco, Frederick A., 211 Palisade av., Union City
Crowley, Leo F., 148 Belmont av., Jersey City
Cufari, Carmine J., 725 18th st., Union City
Culver, S. Herbert, 75 Magnolia av., Jersey City
D'Acerno, Pellegrino A., 346 Palisade av., Union City
Daly, Edmund J., 921 Bergen av., Jersey City
Danielson, John J., 4703 Tonnele av., North Bergen
Davey, Thomas N., 41 West 33rd st., Bayonne
Davis, Daniel, 14 Webster av., Jersey City
DeFuccio, Charles P., 12 Duncan av., Jersey City
DeMarco, Silverino V., 1818 Boulevard, Jersey City
DeMeritt, Charles L., 4622 Boulevard, Union City
Dershimer, Frederick W., 22 Gifford av., Jersey City
Dexter, Harriet E. T., 903 Ave. C, Bayonne
Dillingham, Willis I., 431 15th st., West New York
Dodson, Louis W., 592 Jersey av., Jersey City
Donnelly, Joseph P., 58 Kensington av., Jersey City
Donohoe, Lucius F., 140 W. Eighth st., Bayonne

- Doody, Wm. M., 19 Bentley av., Jersey City
 Doran, Ralph J., 200 11th st., Hoboken
 Doran, Wm. G., 2685 Boulevard, Jersey City
 Dougherty, Daniel D., 1006 Garden st., Hoboken
 Doyle, John J., 426 Fairmount av., Jersey City
 Draesel, Charles, 9027 Hudson Blvd., North Bergen
 Driscoll, Raymond S., 919 Hudson Blvd., Bayonne
 Dukes, Howard R., 220 Kearny av., Kearny
 Edgar, Joseph A., 71 Congress st., Jersey City
 Edwards, Lena F., 358 Pacific av., Jersey City
 Enright, James G., 25 Kensington av., Jersey City
 Evans, J. Lawrence, 7117 Park av., Woodcliff
 Facciolo, Francesco, 562 Hudson Blvd., Bayonne
 Faison, John B., 45 Glenwood av., Jersey City
 Farr, John C., 1111 Bloomfield st., Hoboken
 Fattel, Henry C., 8300 Hudson Blvd., N. Bergen
 Fauquier, Leonard B., 172 Jewett av., Jersey City
 Federer, John J., 69 Columbia ter., Weehawken
 Felitti, Vincent J., 6 75th st., North Bergen
 Feller, William, 283 Bergen av., Jersey City
 Fellman, Morris, 907 Summit av., Jersey City
 Fenimore, Edward D., 77 Grace st., Jersey City
 Fialk, Harry, 4618 Hudson av., Union City
 Ficke, Sylvia A., 884 Summit av., Jersey City
 Fifer, William T., 746 Ave. C, Bayonne
 Fineberg, Bernard J., 113 Bentley av., Jersey City
 Fineberg, Jacob C., 50 Glenwood av., Jersey City
 Finger, Frederick A., 938 Ave. C, Bayonne
 Finke, Chas. H., 317 York st., Jersey City
 Finn, Frederick A., 51 Duncan av., Jersey City
 Finn, Henry R. W., 84 Lembeck av., Jersey City
 Flichtenfeld, Morris, 283 Fourth st., Jersey City
 Flicker, David J., 342 Kearny av., Kearny
 Frank, Morris, 920 Ave. C, Bayonne
 Frank, Nathan, 186 Bowers st., Jersey City
 Franklin, I. Harold, 191 Palisade av., Jersey City
 Freeman, Joseph, 146 W. 32nd st., Bayonne
 Freyberger, George A., 29 48th st., Weehawken
 Frieman, Hyman, 744 Ave. C, Bayonne
 Frundt, Oscar C., 92 Bartholdi av., Jersey City
 Frutig, Harold C., 508 36th st., North Bergen
 Furman, Sol T., 349 Fairmount av., Jersey City
 Garibaldi, Louis J., 1016 Hudson st., Hoboken
 Gerner, Harry E., 2787 Boulevard, Jersey City
 Ghee, Euclid P., 115 Claremont av., Jersey City
 Ginsberg, George, 624 Bloomfield st., Hoboken
 Gleeson, William J., 640 Bergen av., Jersey City
 Gnassi, Angelo M., 130 Wegman Pkwy., Jersey City
 Goldowsky, Ira, 23 Warner av., Jersey City
 Goldstone, Karl H., 16 18th st., West New York
 Goodrich, Stewart L., 812 Ave. C, Bayonne
 Gordon, Isaac L., 1815 Boulevard, Jersey City
 Gorenberg, Harold, 126 Gifford av., Jersey City
 Granelli, Humbert A., 213 Garden st., Hoboken
 Green, Morris, 234 48th st., Union City
 Greenberg, Philip, 1902 Hudson Blvd., Jersey City
 Greenberg, Solomon, 52 Ave. B, Bayonne
 Greene, Albert D., 195 Palisade av., Union City
 Greene, Harry, 3285 Boulevard, Jersey City
 Grieco, Emil H., 196 Broadway, Bayonne
 Grossman, Morris, 921 Bergen av., Jersey City
 Grossman, Rubin, 377 Ave. C, Bayonne
 Gutmann, Erwin K., 229 Bowers st., Jersey City
 Hall, Perry O., 2553 Boulevard, Jersey City
 Halligan, Earl J., 254 Montgomery st., Jersey City
 Halligan, Harold J., 254 Montgomery st., Jersey City
 Halperin, David, 590 Bergen av., Jersey City
 Halpern, Sophia L., 1311 Palisade av., Union City
 Handler, Harry, 305 York st., Jersey City
 Harter, Louis F., 174 Bowers st., Jersey City
 Hartwell, H. Ameroy, 777 Boulevard, E. Weehawken
 Harvey, John W., 818 Ave. C, Bayonne
 Hasking, Arthur P., 318 Montgomery st., Jersey City
 Hauptman, Harry, 88 Sherman pl., Jersey City
 Hekimian, Jacob H., 2314 Palisade av., Union City
 Herradora, Juan R., 2787 Boulevard, Jersey City
 Higgins, Gerald L., 125 Lembeck av., Jersey City
 Higgins, John T., 145 Highland av., Jersey City
 Higgins, Thomas A., 2616 Hudson Blvd., Jersey City
 Hill, William F., 104 Grand st., Jersey City
 Hillel, Joseph, 464 Woodcliff av., Hudson Heights
 Holland, Moses H., 2412 Palisade av., Weehawken
 Hollywood, Jas. L., 219 Danforth av., Jersey City
 Hoops, Harold J., 2203 Hudson Blvd., Jersey City
 Howeth, John L., 14 Duncan av., Jersey City
 Introcaso, Dominick A., 45 Crescent av., Jersey City
 Irving, Henry C., 13 Warner av., Jersey City
 Ishkhanian, Nouri I., 6032 Palisade av., W. New York
 Jacks, Oscar, 476 Mercer st., Jersey City
 Jaffe, Benjamin, 566 Bergen av., Jersey City
 Jaffe, Herman M., 2600 Boulevard, Jersey City
 Jaffin, Abraham E., 41 Emory st., Jersey City
 Jaques, J. Eugenia, 74 Waverly st., Jersey City
 Jensen, Grover H., 451 Bergen av., Jersey City
 Jentz, John H., 63 Sherman pl., Jersey City
 Jones, Clement M., 438 Boulevard, Bayonne
 Jones, J. Morgan, Valley rd., Oakland
 Joseph, Benj. M., 2771 Hudson Blvd., Jersey City
 Judy, Kenneth H., 786 Ave. C, Bayonne
 Justin, Arthur W., 41 Fulton st., Weehawken
 Kainer, Herbert, 851 Boulevard, E. Weehawken
 Kaplan, Herman B., 324 44th st., Union City
 Katz, Jacob D., 115 Fairview av., Jersey City
 Keegan, Thomas D., 8 Gifford av., Jersey City
 Keeney, James C., 1201 Park av., Hoboken
 Kelley, Chas. B. P., 921 Bergen av., Jersey City
 Kelly, Bernard S., 1954 Boulevard, Jersey City
 Kelly, Harry R. J., 311A Brown st., Union City
 Kennedy, John W., 12 Liberty pl., Weehawken
 Kerdasha, George S., 131 75th st., Woodcliff
 Kiely, Eugene M., 800 Hudson st., Hoboken
 Kimmel, M. Leonard, 142 Manhattan av., Jersey City
 Klein, Julius, 1415 Palisade av., Union City
 Kolb, John M., 725 10th st., Union City
 Kooperman, Barnett, 321 60th st., West New York
 Kooperstein, Samuel L., 191 Palisade av., Jersey City
 Koppel, Joseph A., 42 Highland av., Jersey City
 Kraemer, Samuel H., 309 Baldwin av., Jersey City
 Kresch, Philip, 42 West 22nd st., Bayonne
 Kruger, Alfred L., 100 Clifton pl., Jersey City
 Kuhlmann, Alvin E., 527 37th st., Union City
 Kun, Bertram, 135 Belmont av., Jersey City
 Lakiszak, Roman T., 253 Stegman st., Jersey City
 Landshof, Chas. A., 50 Glenwood av., Jersey City
 Lane, Thomas F., 145 Garrison av., Jersey City
 Lange, Louis C., 50 Clifton ter., Weehawken
 Largay, Arthur O., 937 Ave. C, Bayonne
 Larkey, Charles J., 700 Ave. C, Bayonne
 Lawsing, G. Conde, 443 22nd st., West New York
 Lefkowitz, Jacob H., 445 64th st., West New York
 Leining, Albert, 45 48th st., Weehawken
 Leir, J. Krevin, 9 Garrison av., Jersey City
 Lemmerz, Theodore H., 141 Magnolia av., Jersey City
 Levine, G. Irving, 2017 Hudson Blvd., Jersey City
 Linden, Mortimer H., 45 Clendenny av., Jersey City
 Lindroth, Lawrence V., 4633 Hudson Blvd., N. Berg'n
 Lipshutz, Benjamin, 18 West 22nd st., Bayonne
 Lipshutz, Charles, 804 Ave. C, Bayonne
 Little, Alonzo W., 120 Arlington av., Jersey City
 Lobban, Robert B., 2595 Boulevard, Jersey City
 Londrigan, Joseph F., 832 Bloomfield st., Hoboken
 Londrigan, Joseph F., II, 832 Bloomfield st., Hoboken
 Long, Miles T., 2150 Hudson Blvd., Jersey City
 Looi, Wm. A., 549 Pavonia av., Jersey City
 Luczynski, Edw. W., 28 E. 22nd st., Bayonne
 Luippold, Eugene J., 85 Columbia ter., Weehawken
 Lupin, Edward E., 727 Ave. C, Bayonne
 Lynch, Roland J., Mental Disease Hosp., Secaucus
 Lynn, Irving I., 2252 Boulevard, Jersey City
 Macchia, Benjamin J., 358 Arlington av., Jersey City

- MacDonald, John J., 348 Ogden av., Jersey City
Mackin, John J., 596 Bergen av., Jersey City
Madaras, John S., 870 Ave. C, Bayonne
Madden, William L., 83 Gifford av., Jersey City
Madison, Lewis K., 358 Pacific av., Jersey City
Mange, Concetta G., 1 75th st., North Bergen
Mangone, Geo. F., 811 Palisade av., Union City
Maras, Peter E., 80 Tonnele av., Jersey City
Margolin, Samuel J., 1012 80th st., North Bergen
Markowitz, Benj. E., 2157 Hudson Blvd., Jersey City
Markowitz, Irvin B., 2157 Hudson Blvd., Jersey City
Mastromonaco, Joseph D., 790 Ave. C, Bayonne
Matera, Joseph, 506 Garden st., Hoboken
Mathesheimer, Jacob L., 280 Old Bergen rd., Jer. City
Mathews, William J., 938 Hudson st., Hoboken
Matturri, Dominick A., 81 Gifford av., Jersey City
Maturi, Vincenzo E., 814 Hudson Blvd., Bayonne
Maver, William W., 532 Bergen av., Jersey City
McCarron, James A., 341 Ave. A, Bayonne
McCarthy, Cornelius P., 887 Boulevard, Bayonne
McCarthy, John J., 1001 79th st., North Bergen
*McDede, J. Searle, 215 Ege av., Jersey City
McDonald, Frank R., 37 Monticello av., Jersey City
McLean, Herbert E., 92 Fairview av., Jersey City
McLean, Hugh A., 414 17th st., West New York
McLoughlin, Frank J., 558 Jersey av., Jersey City
McLoughlin, John W., 39 W. 26th st., Bayonne
McNenney, Claudio E., 113 Fairview av., Jersey City
Meehan, George E., 117 Mercer st., Jersey City
Meltsner, Louis, 904 Hudson st., Hoboken
Meltzer, Louis, 32 W. 33rd st., Bayonne
Mersheimer, Christian H., 15 Reservoir av., Jer. City
Meyer, William, 2128 New York av., Union City
Meyerson, Noah, 428 59th st., West New York
Mickewich, Stephen A., 650 Ave. C, Bayonne
Miller, Max H., 311 16th st., West New York
Milnis, Bernard, 100 74th st., Woodcliff
Monfort, Robert N., 155 Van Wagenen av., Jer. City
Morley, Grace C., 64 Clifton ter., Weehawken
Morris, David G., 11 W. 26th st., Bayonne
Mount, Elmer M., 74 Sherman pl., Jersey City
Muccia, John J., 7 Tonnele av., Jersey City
Mueller, George H., 102 Summit av., Jersey City
Mulvihill, William J., 275 Hudson Blvd., Bayonne
Murphy, James M., 2757 Boulevard, Jersey City
Murphy, Leo J., 374 West st., Union City
Murphy, Patrick H. W., 27 Jefferson av., Jersey City
Murray, Joseph A., 765 Ave. C, Bayonne
Mustermann, Otto H., 303 48th st., Union City
Muttart, George W., 702 Ocean av., Jersey City
Mutter, Alfred A., 75 Beech st., Arlington
Nafash, Shafeek, 301 Palisade av., Union City
Nalitt, David I., 28 West 33rd st., Bayonne
Newman, Abraham J., 132 Manhattan av., Jersey City
Nicholson, Frank P., 895 Summit av., Jersey City
Nobile, James J., 913 Hudson st., Hoboken
Norton, James F., 58 Kensington av., Jersey City
Norwich, Louis E., 355 Ave. C, Bayonne
Nuse, Edward F., 550½ Jersey av., Jersey City
Ockene, Abraham, 2415 Palisade av., Union City
O'Connor, John J., 434 New York av., Union City
O'Gorman, Michael W., 895 Bergen av., Jersey City
O'Grady, Benson J., 931 Washington st., Hoboken
O'Hanlon, George, Medical Centre, Jersey City
Olpp, Arch. E., 1516 Bergenline av., Union City
O'Neill, John H., 270 Montgomery st., Jersey City
Ortolano, James J., 159 First st., Hoboken
O'Shea, John J., 2200 Palisade av., Weehawken
Oshrin, Henry, 750 Park av., West New York
Osterreicher, Desider, 427 Bergen av., Jersey City
O'Sullivan, John R., 11 Quincy av., Arlington
Owen, Logan S., 938 Hudson st., Hoboken
Pacicco, Michele, 376 Monmouth st., Jersey City
Padney, Edward V., 452 Jersey av., Jersey City
Pagliughi, John J., 401 18th st., Union City
Pearlstein, Frank, 325 60th st., West New York
Pearson, J. Gerald, 819 Washington st., Hoboken
Pellarin, John D., 493 New York av., Union City
Penchansky, Samuel J., 847 Ave. C, Bayonne
Pentel, Louis S., 307 60th st., West New York
Perkel, Louis L., 2801 Hudson Blvd., Jersey City
Perlberg, Harry J., 921 Bergen av., Jersey City
Perrone, Arthur F., 415 60th st., West New York
Peters, Edgar A. P., 394 Bergen av., Jersey City
Peterson, Chas. A., 921 Washington st., Hoboken
Pflug, Ferdinand J., 732 Hudson st., Hoboken
Piltz, George F., 153 25th st., Guttenberg
Pindar, Frederick S., 960 Park av., Woodcliff
Pindar, William A., 7523 Broadway, North Bergen
Pinkerton, Wm. A., 854 Ave. C, Bayonne
Pinks, David K., 921 Bergen av., Jersey City
Piskorski, Abdon V., 604 Jersey av., Jersey City
Plavin, Nathan J., 8010 Hudson Blvd., No. Bergen
Pollak, Berthold S., 100 Clifton pl., Jersey City
Pontery, Herbert B., 89 Bowers st., Jersey City
Potter, Benjamin P., 90 Clifton pl., Jersey City
Povalski, Alex. W. T., 1925 Boulevard, Jersey City
Prince, Samuel, 516 34th st., Union City
Purdy, Charles H., 35 Highland av., Jersey City
Pyle, Louis A., 89 Fairview av., Jersey City
Pyle, Wallace, 15 Exchange pl., Jersey City
Quigley, Frederic J., 543 45th st., Union City
Quinn, John J., 921 Bergen av., Jersey City
Read, Donald B., 105 Hudson st., Jersey City
Reingold, Alexander, 221 Garden st., Hoboken
Reitnauer, John S., 518 44th st., Union City
Rieck, Walter R., 379 Kearny av., Kearny
Rieman, Aloysius P., 3566 Boulevard, Jersey City
Robbins, Henry B., 144 Mercer st., Jersey City
Roberts, Edgar W., 760 Palisade av., W. New York
Rosenberg, Jacob, 692 Bergen av., Jersey City
Rosenstein, Jacob L., 568 Bergen av., Jersey City
Rubenstein, Eli, 800 Ave. C, Bayonne
Rundlett, Emilie V., 79 Prospect st., Jersey City
Ruoff, Andrew C., 2414 New York av., Union City
Russell, David L., 690 Bergen av., Jersey City
Ruvane, Joseph J., 38 Bentley av., Jersey City
Sabini, Cecil F., 257 4th st., Hoboken
Sacco, Anthony G., 2200 New York av., Union City
Sachs, Wilbert, 921 Bergen av., Jersey City
Santangelo, Stephen, 461 Jersey av., Jersey City
Santosky, Benj. B., 20 Tonnele av., Jersey City
Saradarian, Albert V., 2401 New York av., Union City
Schapiro, Joseph, 3514 Palisade av., Union City
Scheer, Eli, 7332 Hudson Blvd., North Bergen
Schept, Samuel S., 523 37th st., Union City
Schlein, August, 707 Park av., Hoboken
Schneckendorf, Samuel J., 179 Harrison av., Jer. City
Schneider, Louis A., 412 17th st., West New York
Schuchner, Wm. F., 550½ Jersey av., Jersey City
Schuck, Traugott J., 58 Ninth st., Hoboken
Schulman, Abraham S., 4518 Boulevard, Union City
Schwarz, Berthold T. D., 2787 Blvd., Jersey City
Schwarz, Henry J., 5560 Hudson Blvd., N. Bergen
Sciarrillo, Louis F., 711 Garden st., Hoboken
Sciorsei, Edward F., 609 Bloomfield st., Hoboken
Scott, Samuel G., 141 Bergen av., Jersey City
Selinger, Samuel, 413 16th st., West New York
Shapiro, Maurice, 750 Ave. C, Bayonne
Shapiro, Nathaniel J., 212 Palisade av., Union City
Shapiro, Saul J., 1215 Palisade av., Union City
Sheeran, Vincent J., 269 Jewett av., Jersey City
Shook, Benjamin E., 284 Bergen av., Jersey City
Shulman, Nathan L., 538 45th st., Union City
Siegel, Lester, 645 Bergen av., Jersey City
Siegler, Julius, 646 Bergen av., Jersey City
Simeone, Peter A., 555 38th st., Union City
Singer, Sina S., 3443 Hudson Blvd., Jersey City
Smith, Alex. L., 2672 Hudson Blvd., Jersey City
Smith, Meyer, 298 Fourth st., Jersey City

Snyder, John E., 1023 Garden st., Hoboken
 Snyder, W. Jay, 74 Columbia ter., Weehawken
 Spalding, Henry J., 512 45th st., Union City
 Spano, Frank, 320 47th st., Union City
 *Spath, George B., 722 Hudson st., Hoboken
 Spath, William H., 722 Hudson st., Hoboken
 Spence, Henry, 2540 Hudson Blvd., Jersey City
 Spohn, Eugene L., 511 Kearny av., Arlington
 Sprague, Seth B., 301 York st., Jersey City
 Stark, Harry L., 680 Hudson Blvd., Bayonne
 Stefansin, Frank, 2020 West st., Union City
 Stein, Albert, 700 85th st., North Bergen
 Stein, Jacob M., 68 Columbia ter., Weehawken
 Stockfish, Robert H., 3637 Boulevard, Jersey City
 Stokes, Anthony T., 819 First st., Secaucus
 Stout, J. Phillip, 165 Jewett av., Jersey City
 Street, Daniel B., 27 Woodlawn av., Jersey City
 Stuart, William C., 518 Hudson st., Hoboken
 Sullivan, James A., 46 Bentley av., Jersey City
 Sulouff, S. Henry, 662 Newark av., Jersey City
 Sussman, Harold, 541 44th st., Union City
 Sweeney, William J., 68 Clifton ter., Weehawken
 Swiney, Juliana C., 325 Ave. C, Bayonne
 Swiney, Merrill A., 325 Ave. C, Bayonne
 Taft, Herman L., 16 48th st., Weehawken
 Talty, John C., 935 Washington st., Hoboken
 Tannert, Carl H., 331 77th st., North Bergen
 Tataryan, Hovsep, 422 New York av., Union City
 Temes, J. Howard, 2216 Boulevard, Jersey City
 Thomas, Ralph B., 793 Montgomery st., Jersey City
 Tidwell, Harold F., 229 16th st., West New York
 Tomaiuolo, Michele, 19 76th st., North Bergen
 Tyndall, Hugh H., 83 Highwood ter., Weehawken
 Urevitz, Abraham, 2415 New York av., Union City
 Utkewicz, Edmond A., 2756 Hudson Blvd., Jersey City
 Varriano, John L., 3263 Hudson Blvd., Jersey City
 Visconti, Joseph A., 711 Garden st., Hoboken
 Vostrosablin, Nicholas A., 121 Grand st., Jersey City
 Vreeland, William N., 32 Bergen av., Jersey City
 Wallack, Eli A., 333 Fairmount av., Jersey City
 Walscheid, Arthur J., 404 38th st., Union City
 Waters, Edward G., 39 Gifford av., Jersey City
 Watman, Anthony J., 2786 Boulevard, Jersey City
 Weber, Walter D., 305 23rd st., Union City
 Wechsler, Joseph, 3342 Hudson Blvd., Jersey City
 Weiss, Abram, 2302 Palisade av., Weehawken
 Weiss, Morris J., 734 Ave. C, Bayonne
 Welcher, Howard A., 7904 Hudson Blvd., N. Bergen
 Wheeler, James A. V., 85 Van Reyden st., Jersey City
 White, Hugh M., 901 Summit av., Jersey City
 White, Thomas J., 50 Glenwood av., Jersey City
 Wilcox, Frank A., 329 16th st., West New York
 Williamson, Wm. L., 22 W. 22nd st., Bayonne
 Woelfle, Henry E., 907 Summit av., Jersey City
 Wolbert, Charles M., 691 Palisade av., Cliffside Park
 Woodruff, Stanley R., 16 Enos pl., Jersey City
 Yeaton, Wm. L., Jr., 204 11th st., Hoboken
 Yudkoff, William, 403 Hudson Blvd., Bayonne
 Zitani, Alfred M., 937 Washington st., Hoboken

Number of Active Members and basis of representation, 453, on March 15, 1941.

Honorary Members

Connell, John, Jersey City	Older, Benjamin, Union City
Gille, Hugo, Jersey City	Rosecrans, James H., Hoboken
Miner, Donald, New York City	Sexsmith, George H., Bayonne
Oestmann, August W., Jersey City	Vreeland, Hamilton, Ridgewood
Zenneck, Junius F., Weehawken	

Resigned

Low, Victor, Jersey City	Posnock, Samuel, Roosevelt, N. Y.
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Transfers

Grossman, Morris, from New York County, N. Y.	Knopf, Edward, to Kings County, N. Y.
Hauptman, Harry, from St. Louis County, Missouri	Siegel, Sidney L., to Cumberland County

HUNTERDON COUNTY (10)

OFFICERS



IVAN B. SMITH
President
Dayton



EDGAR W. LANE
Secretary
Bloomsbury



I. ROLAND BOOTHBY
Treasurer
Clinton



ARTHUR M. JENKINS
Reporter
Frenchtown

Society organized June 12, 1821. Meets on fourth Tuesday of January, April, July, and October, April being the Annual Meeting.

Active Members

Baker, Philip W., High Bridge	Fritz, John F., Jr., 95 Main st., Flemington
Bambara, Aurelius J., Flemington	Fuhrmann, Barclay S., 10 Main st., Flemington
Beatty, Hannah J., Clinton Farms, Clinton	Germain, Raymond J., High Bridge
Boothby, I. Roland, Clinton	Hamilton, Lloyd A., 46 York st., Lambertville
Boyer, Charles G., Annandale	Henry, George, 33 Mine st., Flemington
Christensen, Alexander H., Lebanon	Jenkins, Arthur M., 701 Harrison st., Frenchtown
Clark, Frank G., White House Station	Knox, Howard A., New Hampton
Coleman, Austin H., Clinton	Lane, Edgar W., 46 Main st., Bloomsbury
Crooks, William J., III, Glen Gardner	Leaver, Morris H., Quakertown
Ctibor, Vladimir F., Califon	McCorkle, William E., Ringoes
English, Sam'l B., N. J. State Hospital, GlenGardn'r	Mullins, Roy L., 305 Harrison st., Frenchtown
Fluck, Paul H., 73 N. Union st., Lambertville	Smith, Ivan B., Dayton
	Tompkins, Grenelle B., 52 Broad st., Flemington

Number of Active Members and basis of representation, 25, on March 15, 1941.

Honorary Members

Morrison, J. Bennett, Carlsbad, Calif.	Scammell, Frank G., Trenton
Sommer, George N. J., Trenton	

Transfers

Gross, Max, to Atlantic County	Harmon, B. M., to Essex County
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MERCER COUNTY (11)

OFFICERS



HAROLD C. COX
President
Hightstown



A. DUNBAR HUTCHINSON
Secretary-Reporter
Trenton



HARRY R. NORTH
Treasurer
Trenton

Society organized May 23, 1848. Meets on second Wednesday of each month except July, August, and September, at 8:30 p. m., in the Stacy-Trent Hotel. Annual Meeting in December. Annual Banquet in November.

Active Members

- Abey, W. J. H., 21 E. Delaware av., Pennington
 Abrams, Henry, 195 Nassau st., Princeton
 Ackley, David B., 21 N. Clinton av., Trenton
 Albert, Perry, 2780 S. Broad st., Trenton
 Applegate, Edw. T. R., 1125 Greenwood av., Trenton
 Applestein, Robert, 568 E. State st., Trenton
 Aronis, Harry R., 239 E. Hanover st., Trenton
 Ashley, Harmon H., 192 W. State st., Trenton
 Barrows, Arthur M., 440 Hamilton av., Trenton
 Barry, R. Grant, 908 W. State st., Trenton
 Bayne, Joseph K., Med. Dept., 112th F. A., Ft. Bragg, N. C.
 Bearsto, Everett B., 224 W. State st., Trenton
 Belfer, Jacob J., 1235 Chambers st., Trenton
 Belford, Ralph J., 90 Nassau st., Princeton
 Bellis, Horace D., 437 E. State st., Trenton
 *Belting, Arthur W., 836 West State st., Trenton
 Berman, Jacob J., 409 Market st., Trenton
 Blackwell, Enoch, 28 W. State st., Trenton
 Blaugrund, Samuel, 190 W. State st., Trenton
 Blum, Joseph M., 128 Mill st., Trenton
 Bonnet, W. Laurence, 2791 Not'gh'm wy., Merc'ville
 Borrella, Dominic D., 476 Hamilton av., Trenton
 Buckley, Richard T., Jr., Peddie Sch'l, Hightstown
 Burbidge, J. Raymond, McCosh Infirmary, Princeton
 Burns, Joseph R., 46 S. Olden av., Trenton
 Burroughs, Edmund W., 701 W. State st., Trenton
 Byer, M. Yale, 827 E. State st., Trenton
 Carabelli, A. Albert, 306 Hamilton av., Trenton
 Carroll, C. Walter, 125 Centre st., Trenton
 Carroll, William V., 211 Academy st., Trenton
 Cella, Charles F., 359 Hamilton av., Trenton
 Charleroy, Durant K., 38 Crosswicks st., Bordentown
 Chesner, Wm. A., 1111 Hamilton av., Trenton
 Chianese, C. Chester, 464 Hamilton av., Trenton
 Clark, Alice L., 206 W. State st., Trenton
 Clark, Charles E., New Jersey State Hosp., Trenton
 Cohan, Charles C., 217 W. Hanover st., Trenton
 Cohen, Herman, 1301 Hamilton av., Trenton
 Cohen, William, 1007 Greenwood av., Trenton
 Colavita, James J., 433 Princeton av., Trenton
 Collins, Henry J., 1160 Hamilton av., Trenton
 Comfort, John B., 50 S. Clinton av., Trenton
 Commini, Frank F., 513 Bridge st., Trenton
 Connelly, John A., 212 W. State st., Trenton
 Corio, George A., 307 S. Clinton av., Trenton
 Corrigan, Patrick H., 1720 S. Broad st., Trenton
 Cotton, Henry A., Jr., N. J. State Hosp., Trenton
 Cottone, Rosario J., 683 Princeton av., Trenton
 Cowlbeck, Harry D., 224 W. State st., Trenton
 Cox, Harold C., 208 Stockton st., Hightstown
 D'Arcy, Walter E., 545 E. State st., Trenton
 Davenport, Irwin P., 545 W. State st., Trenton
 Davis, Harold L., 178 W. State st., Trenton
 Davis, John E., Jr., N. J. State Hospital, Trenton
 Davison, Royden W., 205 W. State st., Trenton
 Dean, Guy K., Jr., Princeton rd., Plainsboro
 Deitz, Joseph R., 320 Centre st., Trenton
 Dembinski, T. Henry, 1238 S. Clinton av., Trenton
 Denelsbeck, J. Otis, 878 E. State st., Trenton
 Dimun, John T., 960 S. Broad st., Trenton
 Dodge, James T., 1819 S. Broad st., Trenton
 Doranz, Harold K., 491 Centre st., Trenton
 Drezner, Henry L., 507 S. Warren st., Trenton
 Eames, William N., 1871 Pennington rd., Trenton
 Elias, Elmer J., 474 Greenwood av., Trenton
 Engelhart, Ferdinand K., 701 Stuyves't av., Trenton
 English, Harrison F., III, N. J. State Hosp., Trenton
 Epstein, Ruble, 606 Perry st., Trenton
 Ernest, Richard B., 240 W. State st., Trenton
 Fabian, Paul L., 520 Princeton av., Trenton
 Farmer, Walter D., 28 S. Main st., Allentown
 Fell, Alton S., Donnelly Memorial Hospital, Trenton
 Fessler, A. James, 1544 S. Broad st., Trenton
 Fine, Sydney G., 868 Stuyvesant av., Trenton
 Finegan, Paul J., 200 W. State st., Trenton
 Finkle, Lester J., 225 Perry st., Trenton
 Fiorello, Joseph R., 689 Princeton av., Trenton
 Fluck, David A., 626 W. State st., Trenton
 Forer, Robert, 247 Centre st., Trenton
 Franzoni, Andrew E., 938 Brunswick av., Trenton
 Friedman, Max, 493 Chambers st., Trenton
 Friedman, Meyer H., 526 N. Clinton av., Trenton
 Friedmann, Leonard L., 484 Princeton av., Trenton
 Fuchs, Jacob N., 1267 S. Broad st., Trenton
 Garwood, Norman W., Main st., Crosswicks
 Gindhart, John H., 1233 Hamilton av., Trenton
 Goldberg, Ben. M., 1156 E. State st., Trenton
 Goldman, Leo L., 325 Market st., Trenton
 Graham, Ernest E., 4273 S. Broad st., Yardville
 Guglielmelli, Angelo D., 449 Hamilton av., Trenton
 Guidotti, Frank P., 703 Hamilton av., Trenton
 Hafetz, M. Morris, 114 Centre st., Trenton
 Haggerty, D. Leo, 227 N. Warren st., Trenton
 Haines, Evelyn M., 1022 Greenwood av., Trenton
 Hammell, Frank M., 137 S. Main st., Allentown
 Haney, John J., 850 Hamilton av., Trenton

Harman, James R., 824 W. State st., Trenton
Harman, William J., 740 W. State st., Trenton
Harrop, George A., 33 Cleveland lane, Princeton
Hess, George A., River rd., Titusville
Hiden, Joseph C., 199 Nassau st., Princeton
Hirschfield, Bernard A., 438 Hamilton av., Trenton
Horhovitz, George I., 324 S. Broad st., Trenton
Hunter, Floyd D., 3620 Nottingham way, Hamilt'n Sq.
Hutchinson, A. Dunbar, 913 W. State st., Trenton
Hutchinson, Geo. F., 55 Mercer st., Hamilton Sq.
Ivins, William C., 214 E. Hanover st., Trenton
James, J. Thomas, 199 Nassau st., Princeton
Janoff, Henry, 626 Perry st., Trenton
Jaspan, Samuel C., 820 Division st., Trenton
Johnson, John F., 113 Abernethy dr., Trenton
Kachdorian, Vartan, 930 Brunswick av., Trenton
Kinczel, John A., 971 S. Broad st., Trenton
Klempler, Paul, 637 Greenwood av., Trenton
Kline, Joseph J., 733 Hamilton av., Trenton
Knauer, Charles H., Jr., 304 W. State st., Trenton
Kohn, Joseph J., 207 Calhoun st., Trenton
Kohn, Ralph B., 207 Calhoun st., Trenton
Konder, Joseph S., 978 S. Broad st., Trenton
Koplin, A. Herman, 1239 Greenwood av., Trenton
Koplin, Nathaniel H., 142 W. State st., Trenton
Kustrup, John F., 1418 S. Broad st., Trenton
Lapin, Louis P., 15 Crosswicks st., Bordentown
Lapin, Samuel B., 542 W. State st., Trenton
Larsson, Evert A., N. J. State Hospital, Trenton
Lavine, Barney D., 630 N. Clinton av., Trenton
Lavine, Sidney B., 144 W. State st., Trenton
Leshin, Harry, 564 S. Main st., Hightstown
Lettiere, Anthony J., 425 E. State st., Trenton
Levin, Louis, 651 W. State st., Trenton
Levy, Irvin, 154 W. State st., Trenton
Light, Arthur B., Lawrenceville School, Lawr'nc'v'le
Little, William R., 493 W. State st., Trenton
Lloyd, Samuel J., 178 W. State st., Trenton
Lynch, Donald C., 178 W. State st., Trenton
MacDermid, Lynden, 506 Farnsworth av., Bordent'n
Magson, Albert E., 302 S. Main st., Hightstown
Magee, Harold S., New Jersey State Hosp., Trenton
Majeski, Henry J., 935 Brunswick av., Trenton
McCandliss, Wm. K., N. J. State Hospital, Trenton
McCarthy, William P., 1203 Parkside av., Trenton
McCullough, John H., 523 E. State st., Trenton
McGuigan, Francis A., 212 N. Warren st., Trenton
Means, Paul B., N. J. State Hospital, Trenton
Miller, Earle K., 2502 Nottingham way, Trenton
Miller, Gerald H., N. Main st., Cranbury
Miller, Samuel R., 407 S. Main st., Pennington
Minschwaner, Geo. G., Jr., 954 Greenw'd av., Trenton
Mitchell, Charles H., 1100 W. State st., Trenton
Mitskas, Theo. V. J., 704 Greenwood av., Trenton
Moriconi, Albert F., 438 Hamilton av., Trenton
Mountford, Wm. E., 215 N. Warren st., Trenton
Munro, Jeannette, 2 Queenston pl., Princeton
Murphy, James A., 312 Bellevue av., Trenton
Murto, Thomas V., 532 W. State st., Trenton
Nayfield, Ronald C., 974 S. Broad st., Trenton
Nonziato, Frank A., 50 Centre st., Trenton
North, Harry R., 160 W. State st., Trenton
O'Neill, Joseph F., 41 E. Broad st., Hopewell
O'Rourke, James J., 871 Stuyvesant av., Trenton
Pantaleone, Joseph, 504 Hamilton av., Trenton
Parker, Horace N., 72 N. Clinton av., Trenton
Pessel, Johannes F., 224 W. State st., Trenton
Peterson, Walter R., 312 W. State st., Trenton
Pierson, Carl L., 395 W. State st., Trenton
Pierson, Joseph R., 10 E. Broad st., Hopewell
Pinerman, Robert B., 308 W. State st., Trenton
Pittman, Allen R., N. J. State Hospital, Trenton
Potter, Ellen C., 301 W. State st., Trenton

Powis, Ethel M., 198 W. State st., Trenton
Poyas, Morton L., 306 W. State st., Trenton
Proctor, Francis E., 332 W. State st., Trenton
Purcell, Ernest F., 800 Stuyvesant av., Trenton
Ragany, Joseph, 966 S. Broad st., Trenton
Rainey, Willard G., 34 Bayard lane, Princeton
Rampona, Joseph M., 272 Nassau st., Princeton
Reisinger, Paul B., 369 W. State st., Trenton
Rita, James J., 235 S. Clinton av., Trenton
Rogers, Laurence H., Donnelly Mem. Hosp., Trenton
Rose, William G., 182 Stockton st., Hightstown
Rowan, Henry M., 224 W. State st., Trenton
Sackin, Stanley, 1009 Hamilton av., Trenton
Salway, Benjamin, 321 S. Broad st., Trenton
Scammell, Frank G., 40 S. Clinton av., Trenton
Scasserra, Benedict B., 163 Nassau st., Princeton
Schildkraut, Jacob M., 170 W. State st., Trenton
Seely, Roy B., 78 N. Clinton av., Trenton
Seitzick-Robbins, H. E., 723 W. State st., Trenton
Sekerak, Albert J., 984 S. Broad st., Trenton
Shear, Maurice M., 1158 E. State st., Trenton
Sica, L. Samuel, 431 E. State st., Trenton
Siemion, Theophilus R., 1005 Brunswick av., Trenton
Sill, John B., 942 W. State st., Trenton
Silver, E. Drew, 136 Stockton st., Hightstown
Sinton, John Y., Imlaytown
Slack, Clarence J., 230 W. State st., Trenton
Smith, Houghton C., 1063 S. Clinton av., Trenton
Smith, Paul E., N. J. State Hospital, Trenton
Smith, W. Henley, 126 W. State st., Trenton
Snegreff, Leonid S., 49 Maple av., Trenton
Sommer, Geo. N. J., 120 W. State st., Trenton
Sommer, Geo. N. J., Jr., 120 W. State st., Trenton
Spradley, Jeems B., N. J. State Hospital, Trenton
Steel, John M., N. J. State Hospital, Trenton
Stein, Louis A., 226 W. State st., Trenton
Stone, Robert G., N. J. State Hospital, Trenton
Storaci, Frank S., 715 Hamilton av., Trenton
Summers, Alfred D., 180 Nassau st., Princeton
Sutnick, Theodore B., 1018 S. Broad st., Trenton
Swern, Nathan, 399 W. State st., Trenton
Swertfeger, Herbert W., 22 N. Greenw'd av., Hopew'l
Taylor, Walter A., 450 Rutherford av., Trenton
Tenney, Luman H., Princeton University, Princeton
Tomec, Otto C., 756 Parkway av., Trenton
Treiber, Benjamin A., 219 W. State st., Trenton
Urbaniak, Henry S., 883 Brunswick av., Trenton
Vaczi, Stephen, 983 S. Broad st., Trenton
Vanneman, Joseph S., 45 Princeton av., Princeton
Vol-Tretter, Marta, 501 W. State st., Trenton
Waldron, Edward L., 126 W. State st., Trenton
Walsh, Thomas J., 514 Greenwood av., Trenton
Warter, Peter J., 717 W. State st., Trenton
Waters, Chas. H., 928 W. State st., Trenton
Watov, Samuel E., 615 Beatty st., Trenton
Watson, Fred'k S., 238 W. State st., Trenton
Watts, Wilbur, 436 E. State st., Trenton
Wayman, Bernard R., 834 Stuyvesant av., Trenton
West, Edgar L., 443 E. State st., Trenton
Wiesler, Howard M., 128 Third st., Trenton
Wikoff, John L., 799 Pennington av., Trenton
Wilkes, LeRoy A., 143 E. State st., Trenton
Williams, Geo. W., 829 W. State st., Trenton
Williams, Harry D., 527 E. State st., Trenton
Wilner, Arthur S., 205 Market st., Trenton
Wittenborn, W. F. J., 1635 Brunswick av., Trenton
Wolff, Herbert M., 732 W. State st., Trenton
Wright, Ada V., State Home for Girls, Trenton
Yaeger, Leslie A., 470 Hamilton av., Trenton
Yazujian, Dikran M., 562 E. State st., Trenton
York, Wilbur H., 87 Battle rd., Princeton
Zandt, Frederic B., 16 Mercer st., Hamilton Square
Zimskind, Joshua N., 210 W. State st., Trenton

Associate Members

Austin, Henry J., 96 Bellevue av., Trenton
 Barlow, John D., 194 Stockton st., Hightstown
 Bennett, Robert E., N. J. State Hospital, Trenton
 Bergsma, Daniel, 1 West State st., Trenton
 Berry, Leonard M., 205 Nassau st., Princeton
 Ciuccarelli, Francesco, 225 Hamilton av., Trenton
 Clunan, Ambrose P., Fort Dix
 Forman, Douglas N., N. J. State Hospital, Trenton
 Garber, Robert S., N. J. State Hospital, Trenton

Lavine, Samuel C., 1207 S. Clinton av., Trenton
 Linn, Louis, N. J. State Hospital, Trenton
 Miller, Reginald C., 2014 Greenwood av., Trenton
 Ogden, Andrew E., 1829 Greenwood av., Trenton
 Silver, George A., 3rd, 242 Stockton st., Hightstown
 Tanner, Walter L., N. J. State Hospital, Trenton
 Vento, Sebastian J., Liberty & S. Clinton sts., Trenton
 Wildman, George A., 1720 S. Broad st., Trenton
 Wilner, Irving, 205 Market st., Trenton

Honorary Members

Gordon, Clark H., Trenton
 MacFarland, Burr W., Trenton
 Pierson, Theodore A., Hopewell

Silver, George A., Hightstown
 Turner, Irvine F. P., Titusville
 Wright, Howard E., Princeton

Transfer

Lloyd, Samuel J., from Minnesota

MIDDLESEX COUNTY (12)

OFFICERS



RALPH J. FAULKINGHAM
President
New Brunswick



WILLIAM E. SHERMAN
Secretary
New Brunswick



GEORGE J. KOHUT, JR.
Treasurer
Perth Amboy



CYRIL I. HUTNER
Reporter
Woodbridge

Society organized June 11, 1816. Meets on the third Wednesday of each month, October to June, inclusive. Annual Meeting in December.

Active Members

Anderson, John F., 195 College av., New Brunswick
 Avery, Philip S., 546 Central av., Bound Brook
 Balogh, William A., 315 Front st., Dunellen
 Bassett, Lavern C., 320 New Market rd., Dunellen
 Belafsky, Henry A., 150 Green st., Woodbridge
 Berkow, Samuel G., 138 Market st., Perth Amboy
 Bowman, Ned O., 1001 Georges rd., New Brunswick
 Breslow, Samuel, 157 Market st., Perth Amboy
 Brody, Morton S., 67 Paterson st., New Brunswick
 Brown, Fred. L., 67 Livingston av., New Brunswick
 Burnett, Charles B., 109 Main st., South River
 Calvin, Charles H., 80 Commerce st., Perth Amboy
 Clarke, Francis M., 116 New st., New Brunswick
 Cohen, Nathan B., 232 State st., Perth Amboy
 Cooper, Irving J., 116 Livingston av., New Brunswick
 Copleman, Benjamin, 263 High st., Perth Amboy
 Copleman, H. B., 111 Livingston av., New Brunswick
 Cottrell, Judson G., 159 Market st., Perth Amboy
 Csoma, Emery J., 151 Somerset st., New Brunswick
 Degenhardt, Ira H., 51 Livingston av., New Brunswick
 Dieker, Howard E., 78 Main st., South River
 Downing, Perley E., Sedgwick st., Jamesburg
 Downs, Louis S., 141 Roosevelt av., Carteret

Dunham, Malcolm M., 88 Grove av., Woodbridge
 East, Isaac C., State Home for Boys, Jamesburg
 Eulner, Elmer H., 216 Henry st., South Amboy
 Fagan, James L., 51 Bayard st., New Brunswick
 Fanelli, Antonio, 471 Laurie st., Perth Amboy
 Faulkingham, Ralph J., 61 Livingston av., New Brunswick
 Fazio, Vincent J., 360 Main st., South Amboy
 Feher, Ladislav A. M., 177 Somerset st., New Brunswick
 Fine, Hyman P., 151 Market st., Perth Amboy
 Fine, Irvin J., 256 State st., Perth Amboy
 Fishkoff, Alexander H., 132 Market st., Perth Amboy
 Fithian, George W., 266 High st., Perth Amboy
 Forney, Norman N., 96 N. Main st., Milltown
 Forney, Norman N., Jr., 114 Van Lieu av., Milltown
 Gauzza, Valentine P., 505 New Brunswick av., Fords
 Gessner, Gerard R., 28 S. 3rd av., Highland Park
 Glasser, Benjamin F., 316 George st., New Brunswick
 Goldberg, Harry C., 135 Market st., Perth Amboy
 Goldberg, Isidore, 303 N. Washington av., Dunellen
 Goldman, Solomon, 77 Livingston av., New Brunswick
 Greenwood, Wm. R., 118 Somerset st., New Brunswick
 Grieve, James, 88 Market st., Perth Amboy
 Gurshman, Sol, 280 Amboy av., Metuchen

Gutowski, Jos. M., 433 Brace av., Perth Amboy
Haight, Harry W., 118 Raritan av., Highland Park
Hauber, Eugene A., 6 Quaid st., Sayreville
Haywood, Henry, 49 Paterson st., New Brunswick
Henry, Frank C., Jr., 220 Smith st., Perth Amboy
Hesseltine, Clair E., 269 Bordentown av., So. Amboy
Hilker, George F., 258 Maple st., Perth Amboy
Hinton, Samuel H., 123 Main st., Sayreville
Hofer, Clarence J. M., 463 Main st., Metuchen
Hoffman, Florentine M., 91 Bayard st., NewBrunsk'sk
Hoffman, Charles W., 261 Henry st., South Amboy
Hunt, Melvin M., 140 Jackson st., South River
Hutner, Cyril I., 134 Grove av., Woodbridge
Jablonski, John J., 100 Main st., Sayreville
Jacobson, Murray B., 138 Market st., Perth Amboy
Karshmer, Nathan, 92 Carroll pl., New Brunswick
Kelly, Leo J., 343 Barclay st., Perth Amboy
Kemeny, Imre, 48 Pulaski av., Carteret
Kleiber, Estelle E., 131 Livingston av., New Bruns'k
Klein, Alexander, 328 High st., Perth Amboy
Klein, Edw. F., 136 Market st., Perth Amboy
Klein, William, 85 Bayard st., New Brunswick
Kler, Joseph H., 151 Livingston av., New Bruns'w'k
Koelsch, Frederick J., 14 Kirkpatrick st., N'wBrns.
Kohut, George J., Jr., 473 Amboy av., Perth Amboy
Kovarsky, Albert E., 110 Market st., Perth Amboy
Krafchik, Louis L., 100 Bayard st., New Brunswick
Kramer, Samuel E., 254 State st., Perth Amboy
Lang, Joseph, 111 Market st., Perth Amboy
Lazow, S. Manlius, 199 Main st., Matawan
Leonard, George F., 63 N. 5th av., Highland Park
Levinson, Reubin, 241 State st., Perth Amboy
Lief, Lawrence H., Gatzmer av., Jamesburg
London, William, 255 State st., Perth Amboy
Long, Pauline A., 22 Livingston av., New Bruns'w'k
Lund, John L., 267 High st., Perth Amboy
MacDowall, John L., 113 Market st., Perth Amboy
Mann, Benjamin, 468 Brace av., Perth Amboy
Mann, Jacob J., 255 State st., Perth Amboy
Margaretten, Edward I., 263 High st., Perth Amboy
Mark, Joseph S., 102 Green st., Woodbridge
Marvin, Dorothy H., 51 Livingston av., New Bruns.
Massey, J. Bruce, 20 Codwise av., New Brunswick
McCormick, Wm. H., Jr., 266 Market st., P'thAmboy
McGovern, John F., Jr., 24 Liv'gst'n av., N'wBr'ns'k
McKiernan, Robt. L., 97 Bayard st., New Brunswick
McKinstry, John W., Railroad av., Jamesburg
Meacham, Eugene A., 112 N. Stevens av., So. Amboy
Meinzer, Martin S., 147 Market st., Perth Amboy
Morris, Carlyle, Spring st. & Lake av., Metuchen
Nafey, Herbert W., 51 Livingston av., New Bruns'k
Naulty, Chas. W., Jr., 403 High st., Perth Amboy
Nieman, Solomon Z., 136 Livingston av., NewBrunsk.

Normand, Alphonse F., 113 Market st., Perth Amboy
O'Connell, James J., 116 Livingston av., NewBrunsk'sk
Panigrosso, Louis R., 455 Laurie st., Perth Amboy
Pansy, Abraham A., 12 Jackson st., South River
Pellicane, Anthony J., 183 Livingston av., N'wBr'n'k
Platt, Thomas H., 307 N. Washington av., Dunellen
Reason, John J., 612 Roosevelt av., Carteret
Reitman, Norman, 73 Livingston av., New Bruns'w'k
Rineberg, Irving E., 94 Bayard st., New Brunswick
Rona, Maurice, 10 Kirkpatrick st., New Brunswick
Rothfuss, C. Howard, 574 Rahway av., Woodbridge
Rothschild, Karl, 149 Livingston av., New Bruns'w'k
Rowland, John H., 159 New st., New Brunswick
Rubin, Benjamin, 193 Main st., South River
Runyon, Laurance P., 80 Somerset st., NewBrunsk'sk
Sandella, Joseph F., 138 Livingston av., NewBrunsk'sk
Saulsberry, Chas. E., 75 Livingston av., NewBrunsk'sk
Scott, Frederick W., 103 Bayard st., New Brunswick
Sender, Fannie, 193 Main st., South River
Shayevitz, Abraham S., 102 Main st., South River
Sherman, Wm. E., 88 Schureman st., New Bruns'w'k
Shuill, John V., 84 Market st., Perth Amboy
Siegel, Isadore, 121 Market st., Perth Amboy
Silk, Charles I., 236 High st., Perth Amboy
Slobodien, Benjamin F., 233 High st., Perth Amboy
Smith, John A., 106 Main st., South River
Smith, John V., 463 State st., Perth Amboy
Smith, Joseph A., Roosevelt Hospital, Metuchen
Smith, Marshall, 62 Bayard st., New Brunswick
Smith, Percy L., Ridge rd., Dayton
Spencer, Ira T., 152 Main st., Woodbridge
Spritzer, Theo. D., 102 S. Washington av., Dunellen
Steffens, Charles T., 810 Madison av., Dunellen
Stein, William, 177 Livingston av., New Brunswick
Stephenson, Ruth, N. J. Col. for Women, NewBrunsk'sk
Sullivan, Chas. J., 57 Paterson st., New Brunswick
Szuch, Nicholas, 159 Main st., South River
Taber, Frederick S., 129 Graham st., Highland Park
Toy, Calvert R., 22 Kirkpatrick st., New Brunswick
Tucker, Sidney, 182 Market st., Perth Amboy
Tyrrell, George W., 380 State st., Perth Amboy
Uhr, Jacques S., 127 Livingston av., New Brunswick
Ulan, Jerome, Main st., Spotswood
Urbanski, Adrian X., 148 Market st., Perth Amboy
Urbanski, Matthew F., 314 Washington st., P'hAmboy
Van Dyke, Harry B., 501 Central av., Stelton
Walker, Robert B., 108 Church st., New Brunswick
Walters, George M., 158 Main st., Woodbridge
Weber, John F., 264 Main st., South Amboy
Weiner, Henry T., 111 Market st., Perth Amboy
Wetterberg, Louis F., 74 Grove av., Woodbridge
White, Harry J., Roosevelt Hospital, Metuchen
Wilentz, Wm. C., 188 Market st., Perth Amboy
Witmer, John D., 456 Middlesex av., Metuchen

Number of Active Members and basis of representation, 153, on March 15, 1941.

Associate Members

Cooperman, Eli, 527 New Brunswick av., Fords
Duschock, Edward F., 188 Washington st., P'thAmboy
Friedenthal, Bernard, 88 Livingston av., NewBrns'k
Gadek, Stanley, 95 Fayette st., Perth Amboy
Gereben, Arpad G., 511 Rahway av., Woodbridge
Gobel, Stanley, Raritan & 2nd sts., Middlesex Boro
Gorog, Nicholas M., 159 Bayard st., New Brunswick
Howley, Barth M., Jr., 15 N. 6th av., Highland Park
Landau, Maurice, 839 King George rd., Fords
Lewis, Collins E., 293 Commercial av., NewBrunsw'k
Lucey, James J., 185 Market st., Perth Amboy

Walker, Otto, 72 Roosevelt av., Carteret

McLaughlin, Thomas F., 597 Main st., Metuchen
Miller, George M., 94 Washington av., Carteret
Miller, S. David, 161 New st., New Brunswick
Nelson, Axel R., 35 Williams st., Fords
Richlin, Padie, 316 George st., New Brunswick
Rubin, William, 419 George st., New Brunswick
Salaky, William L., 387 Neville st., Perth Amboy
Schirber, Rene G., 11 Kirkpatrick st., New Bruns'w'k
Smith, Sydney F., 15 S. 3rd av., Highland Park
Sokoloff, Oscar J., 67 Paterson st., New Brunswick
Tisch, Leon, 5 Russell av., Piscatawaytown

Honorary Members

Applegate, Grover T., New Brunswick
Henry, Frank C., Perth Amboy

Ramsey, William E., Perth Amboy
Van Dyke, Benjamin, Cranbury

Transfers

Rubin, Benjamin, from New York County, N. Y.

Stephenson, Ruth, from Philadelphia County, Pa.

MONMOUTH COUNTY (13)

OFFICERS



DANIEL F. FEATHERSTON
President
Asbury Park



WILLIAM F. JAMISON
Secretary-Treasurer
Asbury Park



MURRAY WORONOFF
Reporter
Keyport

Society organized July 24, 1816. Meets on fourth Wednesday of each month from September to June, inclusive. Annual Meeting in April.

Active Members

- Albright, Louis F., 118 Madison av., Spring Lake
 Altschul, Frank J., 177 Garfield av., Long Branch
 Baeseman, R. Winfield, 501 Grand av., Asbury Park
 Baker, Elsworth F., N. J. State Hosp., Marlboro
 Bar, Samuel, 54 Main st., Englishtown
 Becker, Sidney D., 140 Maple pl., Keyport
 Beveridge, Wm. W., 1000 Grand av., Asbury Park
 Binder, Joseph, 101 Third av., Long Branch
 Blaisdell, C. Byron, 489 Broadway, Long Branch
 Bornstein, Paul K., 415 S. Lake drive, Belmar
 Brindle, Harry R., 501 Grand av., Asbury Park
 Brown, Edith L., 332 Woodland av., Avon
 Brown, Harvey S., 5 Club pl., Freehold
 Brown, Kenneth G., 501 Grand av., Asbury Park
 Bullwinkel, Fred'k., Ocean Blvd., Atlantic Highlands
 Campbell, Wm. K., 96 Third av., Long Branch
 Carey, David S., 11 E. Main st., Freehold
 Carter, Joseph F. S., 142 Atkins av., Asbury Park
 Captanian, Aram A., 154 Main st., Matawan
 Casagrande, Stephen R., 600 7th av., Belmar
 Ciampa, Ralph P. E., 383 Bath av., Long Branch
 Clark, John C., 501 Grand av., Asbury Park
 Colby, Maxwell X., 133 Chelsea av., Long Branch
 dePons, Sarah C., 501 Grand av., Asbury Park
 DeVita, Anthony J., Wilson av., Port Monmouth
 Dewis, Edwin G., 21 Westra st., Interlaken
 Diamond, David I., Oceanport av., Oceanport
 Duvall, Albert I., N. J. State Hospital, Marlboro
 Edelson, Samuel, 1141 Corlies av., Neptune
 Ellenson, Solomon S., 507 4th av., Asbury Park
 Fairbanks, Warren H., 27 Broadway, Freehold
 Featherston, Daniel F., 506 4th av., Asbury Park
 Feinberg, Harry D., 384 2nd av., Long Branch
 Feldman, Joel, 81 Broad st., Eatontown
 Feman, J. George, 141 Main st., Keansburg
 Fenton, Tennant E., 320 Ludlow av., Spring Lake
 Fisher, James A., 501 Grand av., Asbury Park
 Freedman, Harold H., 63 W. Main st., Freehold
 Gesswein, Carl A., 35 Church st., Matawan
 Glazer, Edward, 501 Grand av., Asbury Park
 Goff, Frank J., 64 Maple av., Red Bank
 Gordon, J. Berkeley, N. J. State Hospital, Marlboro
 Graves, Charles C., Jr., N. J. State Hosp., Marlboro
 Guillium, Wm. H., 505 4th av., Asbury Park
 Haines, Emerson S., 500 8th av., Asbury Park
 Halbstain, Bernard M., 138 Bath av., Long Branch
 Hancock, Michael Q., 705 D st., Belmar
 Hardy, John W., 53 Main st., Farmingdale
 Hausman, Samuel W., 50 W. Front st., Red Bank
 Heatley, William, 23 Monmouth st., Red Bank
 Herrman, Wm. G., 501 Grand av., Asbury Park
 Heyman, Ernest, 345 Broad st., Red Bank
 Hill, John A., 511 Cedar av., Allenhurst
 Hindle, F. Lawton, 145 Maple av., Red Bank
 Hodas, Sidney M., 158 Maple av., Red Bank
 Holman, Francis W., 123 Broad st., Keyport
 Holters, Otto R., 1002 Emory st., Asbury Park
 Ingling, Harry W., 51 W. Main st., Freehold
 Jamison, Wm. F., 501 Grand av., Asbury Park
 Jarecki, Max M., 527 Bangs av., Asbury Park
 Jones, Granville L., N. J. State Hospital, Marlboro
 Jordan, Alexander D., 238 E. Main st., Manasquan
 Jordan, Joseph C., Box A, Manasquan
 Kanes, Edmund S., 82 Bingham av., Rumson
 Kazmann, Harold A., 406 Broadway, Long Branch
 Knapp, Victor, 505 Second av., Asbury Park
 Krohn, Marc, Campbell av., Belford
 Leighton, Robt. L., 401 Ludlow av., Spring Lake
 Leonard, Lothair L., 615 Asbury av., Asbury Park
 Levin, Jack, 45 E. Main st., Freehold
 Lewis, Jacob, 43 Court st., Freehold
 Lorenzo, Michael J., 75 Riverside av., Red Bank
 Lussier, George H., N. J. State Hospital, Marlboro
 MacKenzie, Robt. A., 501 Grand av., Asbury Park
 Makin, John B., 501 Grand av., Asbury Park
 Manahan, Daniel V., 55 E. Front st., Red Bank
 Martin, Leonard J., 206 Prospect av., Asbury Park
 Mason, Howard B., 90 W. Main st., Freehold
 Matthews, William, 139 Broad st., Red Bank
 McCreight, D. Wade, N. J. State Hosp., Marlboro
 McDonnell, George J., 80 W. Main st., Freehold
 McKelvie, Julius C., 55 Rockwell av., Long Branch
 McTague, Robert S., 88 3rd av., Atlantic Highlands
 Metzger, Karl F., 401 5th av., Belmar
 Miele, Frank A., 314 Carr av., Keansburg
 Moffat, Barclay W., Nut Swamp rd., Red Bank
 Murphy, Chas. M., 21 Main st., Farmingdale
 Neiderhoffer, Sydney L., 469 Broadway, Long Branch
 Nichols, Stanley H., 517 Broadway, Long Branch
 Nientzow, Frank, 55 E. Main st., Freehold
 O'Mara, John A., 314 St. Clair av., Spring Lake
 Opfermann, John L., 167 Bay av., Highlands
 Osborn, A. Downey, 519 Sixth av., Belmar
 Parker, James W., 175 Shrewsbury av., Red Bank
 Parry, Oliver K., 601 Bangs av., Asbury Park
 Pattenden, Franklin J., 300 2nd av., Asbury Park

Perrine, Cornelius C., 668 River rd., Fair Haven
Perrotta, Anthony J., 94 Maple av., Red Bank
Pieper, Howard C., 426 Bath av., Long Branch
Pietri, Raoul, 501 Grand av., Asbury Park
Podell, A. Alfred, 51 E. Front st., Red Bank
Pons, Carlos A., 501 Grand av., Asbury Park
Pregnall, James P., 501 Grand av., Asbury Park
Quirk, Martin A., 90 W. Front st., Red Bank
Raffetto, Joseph F., 550 Cookman av., Asbury Park
Reynolds, Donald G., 64 W. Main st., Freehold
Reynolds, George G., 64 W. Main st., Freehold
Robinson, Ernest A., 149 Atkins av., Asbury Park
Robinson, Wm. A., 62 Main av., Ocean Grove
Rosenthal, Abraham, 43 3rd av., Atlantic Highlands
Rowland, James J., 321 Bay av., Water Witch
Rullman, Walter A., 58 W. Front st., Red Bank
Sacco, Gregory E., 191 Broad st., Red Bank
Sayre, William D., Box 202, Red Bank
Schlossbach, Theodore, 94 S. Main st., Ocean Grove
Schmidt, Albert F., 81 Union av., Manasquan

Scott, Elmer A., Belle Mead San., Belle Mead
Sewell, Stephen, 320 Passaic av., Spring Lake
Shanik, William, 600 4th av., Asbury Park
Silverstein, Max, 605 1st av., Asbury Park
Slocum, Harry B., 263 Bath av., Long Branch
Stevenson, Geo. S., R. D. No. 1, Everett rd., R'd Bank
Straughn, Clinton C., 23 Monmouth st., Red Bank
Strauss, Arthur, 130 Pavilion av., Long Branch
Thomas, Harry G., 1113 5th av., Asbury Park
Trippe, Clarence M., 702 Asbury av., Asbury Park
Upham, Helen F., 305 Third av., Asbury Park
Villapiano, Jos. G., 701 Sunset av., Asbury Park
*Wallin, Alfred C., 166 Main st., Matawan
Watkins, Robert E., 517 Fifth av., Belmar
Wilbur, Franklin L., 711 Grand av., Asbury Park
Wilkins, Stanley O., 47 E. Front st., Red Bank
Wilson, Robert B., 91 Broad st., Red Bank
Wise, Lester D., 119 Morris av., Long Branch
Woodruff, Ralph G., Main st., Englishtown
Woronoff, Murray, 120 Main st., Keyport

Number of Active Members and basis of representation, 136, on March 15, 1941.

Associate Member

Wainwright, Melvin A. R., 286 Broad st., Red Bank

Honorary Member

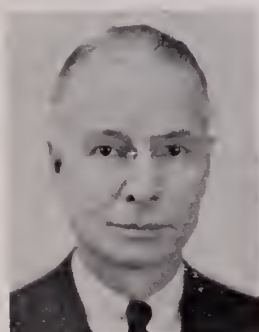
Ransohoff, Nicholas, Long Branch

Transfer

Bailey, Charles P., to Philadelphia County, Pa.

MORRIS COUNTY (14)

OFFICERS



W. BLAKE GIBB
President
Morristown



GEORGE J. YOUNG
Secretary
Morristown



J. HENRY HARRINGTON
Treasurer
Rockaway



F. CLYDE BOWERS
Reporter
Mendham

Society organized June 11, 1816. Meets on the third Thursday in October, December, March and June. Annual Meeting in June.

Active Members

Ackermann, Edward, 5 Richards av., Dover
Allaben, Anna L., 165 South st., Morristown
Atkinson, John M., 93 Greenwood av., Madison
Baker, Augustus L., 389 W. Blackwell st., Dover
Beaver, Jennie D., 44 Elm st., Morristown
Bertha, Nicholas A., 301 S. Main st., Wharton
Bird, Frank L., Main st., Netcong
Blanchard, Charles L., 28 E. Blackwell st., Dover
Bobadilla, Juan E. B., 2 Mercer st., Dover

Booth, William K., 304 William st., Boonton
Bowers, F. Clyde, Mountain av., Mendham
Byrne, J. Arthur, 16 Elm st., Morristown
Carberry, Edw. T., 83 S. Main st., Wharton
Cohen, Oscar H., 115 Church st., Boonton
Collins, Laurence M., N. J. State Hosp., Greystone Pk
Comeau, Geo. W., 415 Speedwell av., Morris Plains
Costello, William F., 55 W. Blackwell st., Dover
Coultas, Aldo B., 1 Madison av., Madison

Crandell, Archie, N. J. State Hosp., Greystone Park
 Curry, Marcus A., N. J. State Hosp., Greystone Park
 DeFelice, Mario T., 28 Mt. Airy rd., Bernardsville
 Deichman, Charles H., 39 Elm st., Morristown
 DeRosa, Louis, Main av., Stirling
 Dochtermann, Warren P., 532 Main st., Chatham
 Donovan, Joseph, N. J. State Hosp., Greystone Park
 Earp, Ruth, 15 Olcott av., Bernardsville
 Eckhardt, Ralph A., 50 Green Village rd., Madison
 Evans, Edgar J., Hinchman av., Denville
 Failmezger, Theodore R., 125 Green av., Madison
 Ferriss, Ruth B., 51 Maple av., Morristown
 Forbes, John S., Jr., Cedar st., Basking Ridge
 Frost, Inglis F., 181 South st., Morristown
 Gambill, Perry J., N. J. State Hosp., Greystone Park
 Geary, Daniel J., 40 Maple av., Morristown
 Gibb, W. Blake, 26 Maple av., Morristown
 Gilbertson, Robert L., 55 Maple av., Morristown
 Glazebrook, Francis H., "Honeysuckle W'ds," Rumson
 Gordon, Charles D., Mt. Arlington
 Graddick, Lester W., 22 Sussex av., Morristown
 Gregory, Marie F., 50 Green Village rd., Madison
 Griscom, I. Norwood, 204 Church st., Boonton
 Hampton, Geo. R., N. J. State Hosp., Greystone P'k
 Harrington, J. Henry, 126 E. Main st., Rockaway
 Hatch, Harold S., Shonghum Sana., Morristown
 Haven, Samuel C., 14 Elm st., Morristown
 Hiler, Stuart A., 62 Rockaway av., Rockaway
 Hogan, Marshall D., 311 W. Main st., Boonton
 Hubert, Antonio O., 131 E. Main st., Rockaway
 Johnston, Julian F., 21 Van Doren av., Chatham
 Judd, Wilbur M., N. J. State Hosp., Greystone Park
 Kessler, Edward L., N. J. State Hosp., Greystone P'k
 King, Alden P., 400 W. Blackwell st., Dover
 Kinkead, Hilda, 56 Prospect st., Madison
 Kossmann, Walter J., Long Valley
 Krauss, Fletcher I., 407 Main st., Chatham
 Kuite, George B., 435 Speedwell av., Morris Plains
 Larson, Henry M., 35 Franklin st., Morristown
 Lasley, James M., N. J. State Hosp., Greystone Park
 Lathrope, George H., 965 Broad st., Newark
 Laudig, Guy H., 361 Speedwell av., Morris Plains
 Loksa, Harold T., 520 Washington st., Boonton
 Luippold, Eugene J., Jr., 318 Washington st., Boont'n
 Mathews, Raymond H., 186 South st., Morristown
 McCluskey, Harry B., Morristown rd., Whippany
 McElroy, Ervin, 20 Main st., Rockaway
 McMahon, Bernard C., 18 DeHart st., Morristown
 McMurray, Geo. B., N. J. State Hosp., Greystone P'k
 Michell, George E., 221 High st., Hackettstown
 Mills, Clifford, 36 Maple av., Morristown
 Musetto, Carmelo A., 135 Cornelia st., Boonton
 Mutchler, Julia, 153 E. Blackwell st., Dover
 Mutchler, H. Raymond, 153 E. Blackwell st., Dover
 Navazio, Attilio, 185 Speedwell av., Morristown
 Nicoll, George L., 25 MacDavitt pl., Dover
 Parry, Allen A., 46 Green Village rd., Madison
 Parry, Antoinette R., 46 Green Village rd., Madison
 Pinckney, Frank H., 186 South st., Morristown
 Plume, Clarence A., Main st., Succasunna
 Pottinger, William E., 6 Altamont court, Morristown
 Prager, Bert A., 251 Main st., Chatham
 Rice, Franklin W., 184 South st., Morristown
 Riley, Philetus H., 26 Maple av., Morristown
 Rosenberg, Alvin A., 22 High st., Morristown
 Rubens, Otto, 27 E. Blackwell st., Dover
 Rubin, Henry S., 11 High st., Morristown
 Rubin, Samuel, 45 East Blackwell st., Dover
 Ryman, Merlin T., 5 Dunbar st., Chatham
 Saltus, Lloyd S., 16 Elm st., Morristown
 Schulman, Robert, Aurora Institute, Morristown
 Scott, Harold R., 10 Speedwell av., Morristown
 Seward, Frederic H., 40 Green Village rd., Madison
 Sherman, Benjamin, Aurora Institute, Morristown
 Sherman, Byron G., 52 Maple av., Morristown
 Smith, Malcolm K., 22 Madison av., Morristown
 Spencer, Alvan, 395 W. Blackwell st., Dover
 Stage, Earl D., 11 James st., Morristown
 Talmage, William G., Main st., Succasunna
 Taylor, Malcolm C., 181 South st., Morristown
 Teller, Daniel W., 28 DeHart st., Morristown
 Terreri, D. Joseph, 30 High st., Morristown
 Teskey, Stanley, 10 Anderson rd., Bernardsville
 Thomas, Thomas S., Jr., 18 Elm st., Morristown
 Van Sickle, Albert W., Chester
 von Deilen, Henry O., 28 DeHart st., Morristown
 Voorhies, Wm. S., Jr., N. J. State Hosp., Gr'stone P'k
 Voss, J. Landon, 21 Mt. Airy rd., Bernardsville
 Wade, Francis A., 196 South st., Morristown
 Ward, Albert J., 39 Elm st., Morristown
 Washburn, Philip C., N. J. State Hosp., Gr'stone P'k
 Weiss, Herman, Aurora Institute, Morristown
 Williams, David P., 284 Morris av., Mountain Lakes
 Williams, Louis E., 80 Green av., Madison
 Woodman, Charles B., 26 Maple av., Morristown
 Young, Gerge J., 60 Maple av., Morristown
 Zimmerman, Robt. F., 28 Washington av., Morrist'n
 Zuck, John A., Main st., Netcong

Number of Active Members and basis of representation, 116, on March 15, 1941.

Courtesy Members

Joy, Homer T., Morristown
 Knight, Augustus S., Peapack
 van Beuren, Frederick T., Jr., Morristown

Honorary Members

Coultas, Aldo B., Madison
 Glazebrook, Francis, Rumson
 Haven, Samuel C., Morristown
 Mills, Clifford, Morristown
 Seward, Frederick H., Madison

Resigned

Heinig, Frank, Boonton
 Lane, Arthur G., St. Petersburg, Fla.

Transfers

Chapman, Walter, to Passaic County
 French, Frank S., to Rochseter, N. Y.

OCEAN COUNTY (15)

OFFICERS



WILLIAM E. DODD
President
Beach Haven



CARL MENGE
Secretary
Toms River



LOUIS R. CARMONA
Treasurer
Tuckerton



RAYMOND A. TAYLOR
Reporter
Lakewood

Society organized October 28, 1903. Meets on second Wednesday of each month except July and August. Annual Meeting in May.

Active Members

Appleton, Ralph, Lincoln av., Point Pleasant
Blumberg, A. William, New Egypt
Buermann, Robert, 206 Madison av., Lakewood
Bunnell, Frederick N., 22 S. Main st., Barnegat
Carmona, L. Roberto, 141 Wood st., Tuckerton
Dodd, Wm. E., Ocean st. & Bay av., Beach Haven
Falkinburg, LeRoy W., Atl'nticC'yBlvd., Forked Riv'r
Gaumer, George W., 422 First st., Lakewood
Goldstein, Abraham, 404 Madison av., Lakewood
Green, Thomas J., New Egypt
Henriksen, J. Bruce, 422 River av., Point Pleasant
Herbener, Eugene G., 423 Third st., Lakewood
Hogan, James J., New Egypt
Ivory, Harry S., Richmond av., Point Pleasant

Joy, Ernest H., 802 N. Main st., Toms River
Lehmacher, Frank, 16 Central av., Lakewood
Menge, Carl H., 236 Washington st., Toms River
Nyvall, Pierre J., Barnegat
Obert, J. Edwin, Main st., New Egypt
Pecora, Carmine L., Atlantic City Blvd., Beachwood
Sawyer, Blackwell, 109 Washington st., Toms River
Schneider, Clinton R., 125 N. Green st., Tuckerton
Sickel, Emanuel M., 220 Madison av., Lakewood
Szold, Norman F., 701 Princeton av., Lakewood
Taylor, Raymond A., 58 Madison av., Lakewood
Thompson, Theodore F., 316 First st., Lakewood
Tilles, Samuel, 44 Sheridan av., Seaside Heights
Towbin, Adolph, 326 Third st., Lakewood
Witte, C. Norman, 422 River av., Point Pleasant

Number of Active Members and basis of representation, 29, on March 15, 1941.

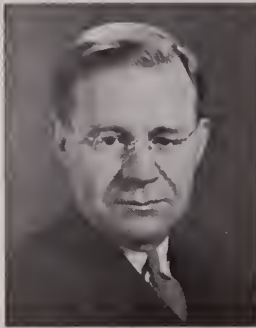
Associate Members

Citta, J. Philip, Toms River

Neiman, Watson E., 618 Forman av., Pt. Pleasant
Smith, Edward C., 111 Fourth av., Lakewood

PASSAIC COUNTY (16)

OFFICERS



FRANCIS W. ASH
President
Paterson



J. ALLEN YAGER
Secretary
Paterson



HARRY WOLFSON
Treasurer
Paterson



IRVING ORIN
Reporter
Passaic

Society organized January 14, 1844; Society chartered November 14, 1843. Meets on second Thursday of each month except June, July, and August. Annual Meeting in May.

Active Members

- Ackerhalt, Martin J., 408 Clifton av., Clifton
 Allen, Arthur A., 365 Park av., Paterson
 Allen, James M., 657 Main av., Passaic
 Alpren, Bernard F., 34 Auburn st., Paterson
 Apter, Abraham H., 528 E. 29th st., Paterson
 Armstrong, Robt. R., 114 Pennington av., Passaic
 Ash, Frank W., 180 Carroll st., Paterson
 Atkinson, James W., 603 S. Maple av., Glen Rock
 Atwood, Edward A., 360 Park av., Paterson
 Averbach, Jacob, 435 Clifton av., Clifton
 Barlow, Frank A., 965 Madison av., Paterson
 Barolsky, Benj., 306 Broadway, Paterson
 Barr, Joseph, 975 Madison av., Paterson
 Becker, Frank F., 298 Diamond Br. av., Hawthorne
 Becker, George L., 646 E. 28th st., Paterson
 Becker, Leo V., 69 Ward st., Paterson
 Bender, Theo., 666 Broadway, Paterson
 Benjamin, Joseph F., 203 Godwin av., Ridgewood
 Bergin, Joseph V., 315 Broadway, Paterson
 Berk, M. David, 33 Bartholf av., Pompton Lakes
 Berkhout, Peter G., 106 Ha'edon av., Prospect Park
 Beshlian, Hagop K., 7 Lee pl., Paterson
 Biczak, Arkad K., 311 Lexington av., Clifton
 Bohl, Louis J., 320 Broadway, Paterson
 Bongiorno, Henry D., 516 River st., Paterson
 Bonynge, Henry A., 123 Prospect st., Ridgewood
 Bornstein, David, 80 Carroll st., Paterson
 Botbyl, Burt W., 927 Madison av., Paterson
 Boylan, Lawrence B., 630 Main st., Paterson
 Brancato, Peter, 17 Church st., Paterson
 *Brevoort, Henry H., 54 Main st., Lodi
 Brogan, Francis B., 84 Ward st., Paterson
 Bromberg, Chas. B., 107 Lexington av., Passaic
 Brooks, Sidney S., 380 12th av., Paterson
 Budd, J. Reuben, 379 Clifton av., Clifton
 Bullen, Victor E., 148 Hamilton av., Paterson
 Butterfield, Arey A., 135 Ayerigg av., Passaic
 Calligaro, Egildo A., 75 Clifton av., Clifton
 Carlisle, John H., 129 Prospect st., Passaic
 Carlough, David J., 426 Ellison st., Paterson
 Catanzaro, Francesco, 151 Jefferson st., Passaic
 Chapman, Walter L., 125 McKinley av., Hawthorne
 Chapnick, Maurice M., 117 Paterson st., Paterson
 Chase, William E., 137 Gregory av., Passaic
 Cherry, Homer H., Valley View Sana., Paterson
 Chester, Saul W., 634 Broadway, Paterson
 Chilton, Forrest S., Newark-Pmptn.Tpk., Pmptn.Pl'ns
 Chipley, Bascomb L., Valley View Sana., Paterson
 Chrisman, Irving, 408 Ellison st., Paterson
 Ciccone, Anthony C., 389 Grand st., Paterson
 Clay, Thomas A., 351 Totowa av., Paterson
 Close, Byron H., Hamburg Trnpg., Bloomingdale
 Cogan, Henry, 616 Tacoma av., Buffalo, N. Y.
 Cohen, Julian, 475 Park av., Paterson
 Cohen, Louis, 257 Paulison av., Passaic
 Cohen, M. Marvin, 137 Graham av., Paterson
 Cohn, Isidor, 231 Lexington av., Passaic
 Cole, L. Frank, 242 Broadwav, Passaic
 Connolly, Joseph P., 64 Hamilton st., Paterson
 Connolly, T. Vincent, 56 Hamilton st., Paterson
 Conserva, Peter V., 215 Dayton av., Clifton
 Cortese, Alvin E., 26 Ward st., Paterson
 Cotton, Norman T., 219 Graham av., Paterson
 Cremens, John F., 144 Carroll st., Paterson
 Crescente, Fred J., 827 Madison av., Paterson
 Crounse, David R., 84 Broadway, Passaic
 Curtis, A. Maurice, 445 Van Houten st., Paterson
 Davis, A. Hobson, Paterson Gen. Hosp., Paterson
 Dawson, Harry, 618 E. 24th st., Paterson
 DeBell, Peter J., 65 Summer st., Passaic
 DeGrace, Francis H., 344 Gregory av., Passaic
 Deich, Samuel R., 162 Lexington av., Passaic
 Delario, Anthony J., 294 Broadway, Paterson
 De'laPenna, Samuel J., 502 Ramapo av., Pmptn.Lks.
 Del Mauro, Alphonse, 460 Park av., Paterson
 DeMattia, Michael, 71 Ward st., Paterson
 De Rosa, Armand, 262 Totowa rd., Totowa Borough
 De Rosa, John, 150 Fair st., Paterson
 Desmet, Victor F., 324 Broadway, Paterson
 De Yoe, Leon E., 602 Broadway, Paterson
 Dingman, Norman M., 330 Broadway, Paterson
 Doktor, David, 288 Hamilton av., Paterson
 Donnelly, Joseph E., 445 Market st., Paterson
 Douglass, Stephen A., Valley View Sana., Paterson
 Dow, Robt. F., 592 East 29th st., Paterson
 Drake, Daniel E., Union Valley rd., Newfoundland
 Duncan, Owsley B., 606 E. 26th st., Paterson
 Dunning, Walter L., 533 River st., Paterson
 Dwyer, Henry E., 261 Madison st., Passaic
 Dwyer, William A., 99 Park av., Paterson
 Edlkraut, Edward C., 129 Highland av., Passaic
 Ehrenfeld, Edward, 185 Lexington av., Passaic

Ehrenfeld, Irving, 185 Lexington av., Passaic
 Eklings, Frank P., 221 Broadway, Paterson
 Esposito, Anthony L., 478 Clifton av., Clifton
 Farkas, Gustav, 95 Jackson st., Passaic
 Feigenoff, Israel, 665 Broadway, Paterson
 Fenster, Morton N., 211 Lexington av., Passaic
 Ferrary, Paul B., 232 Totowa rd., Totowa Boro
 Fiering, Abraham M., Pompton Tnpk., M'tainView
 Fisher, Samuel, 808 Madison av., Paterson
 Fliteroft, William, 510 River st., Paterson
 Freedman, Jacob S., 178 Hamilton av., Passaic
 Gallardo, Agustin, 61 Lakeside av., Pompton Lakes
 Gallo, James S., 594 Broadway, Paterson
 Geiger, Harold C., Main st., West Milford
 Gelman, Sidney, 579 Broadway, Paterson
 Giambra, Sante M., 666 Broadway, Paterson
 Gillson, Hugh V., 21 Lee pl., Paterson
 *Gillson, John T., 170 Broadway, Paterson
 Ginsburg, Samuel, 227 Paulison av., Passaic
 Gladstone, Sidney A., Barnert Mem. Hosp., Paterson
 Glasgow, Thomas M., 120 Passaic av., Passaic
 Gochman, Harry M., 166 Hamilton av., Paterson
 Goldenberg, Raphael R., 588 E. 27th st., Paterson
 Golding, Harry N., 180 Carroll st., Paterson
 Gordon, Abel, 616 Main av., Passaic
 Gordon, Samuel, 515 Broadway, Paterson
 Gormley, Cyrus M., 15 Kiel av., Butler
 Gould, John H., 123 Prospect st., Ridgewood
 Graeter, F. Albert, 265 Gregory av., Passaic
 Graham, Archibald F., 42 Park av., Paterson
 Graham, Theodore K., 279 Park av., Paterson
 Greengrass, Jacob J., 146 Broadway, Paterson
 Gurnee, Quinby D., 168 Diamond Br. av., Hawthorne
 Hagen, Orville R., 266 Van Houten st., Paterson
 Hall, Wayne W., 266 Van Houten st., Paterson
 Halnan, John J., Jr., 631 Madison av., Paterson
 Hambright, Arthur M., Wyckoff av., Ramsey
 Harreys, Chas. W., 153 Prospect st., Ridgewood
 Hatem, Elias J., 1046 Main st., Paterson
 Hillmann, Frederick C., 64 Hamilton st., Paterson
 Hollingsworth, H. Hale, 86 First st., Clifton
 Holmes, Thomas J. E., 151 Fair st., Paterson
 Holster, Stephen G., 951 Madison av., Paterson
 Holt, Herman H., 256 Graham av., Paterson
 Hughes, J. Vernon, 655 Main av., Passaic
 Ianacone, John A., 310 Fifth av., Paterson
 Iraggi, James V., 158 Gregory av., Passaic
 Ives, Edwin I., 24 Stevens av., Little Falls
 Izenberg, David, 555 East 29th st., Paterson
 Jaffe, Hyman, 149 Broadway, Passaic
 Jahn, Albert G., 657 Main av., Passaic
 Jani, Frank F., 297 Lexington av., Passaic
 Jarmulowsky, Harry, 181 E. 33rd st., Paterson
 Jehl, Joseph R., 305 Clifton av., Clifton
 Joelson, Dora, 485 Park av., Paterson
 Joelson, Morris S., 577 Broadway, Paterson
 Joffe, Philip M., 556 E. 28th st., Paterson
 Joffe, Sidney H., 556 E. 28th st., Paterson
 Johnsen, Sigurd W., 149 Prospect st., Passaic
 Joseph, Morris, 271 Lexington av., Passaic
 Joyce, Leo H., 259 Madison st., Passaic
 Katz, Herbert I., 278 Park av., Paterson
 Keating, Charles A., 177 Ellison st., Paterson
 Keating, Joseph M., 275 Passaic av., Passaic
 Keller, Michael L., 673 East 27th st., Paterson
 Kennedy, A. Andrew, 6 Eagle av., Paterson
 Kennedy, Eugene T., 413 Wanaque av., Pmptn. Lks.
 Kim, Gay B., 703 Main st., Paterson
 Kinney, Burton O., 41 Lincoln av., Little Falls
 Kleiner, Samuel, 162 Hamilton av., Paterson
 Koenig, Bertram, 306 Broadway, Paterson
 Koerber, George, 136 Prospect st., Passaic
 Kovaleski, Walter A., 77 Market st., Passaic
 Kovin, Abraham, 123 Lexington av., Passaic
 Kroll, Adolph, 103 Van Buren st., Passaic

Kuhl, John P., 38 Main st., Butler
 Laauwe, Harold W., 198 Haledon av., Prospect Park
 Labash, Charles S., 83 Quincy st., Passaic
 Landaw, Louis, 631 E. 26th st., Paterson
 Lawrence, Elias D., 365 Union av., Paterson
 Leach, John E., 372 Park av., Paterson
 Lee, Frederick P., 606 E. 27th st., Paterson
 Leibovitz, Altan C., 261 Lexington av., Passaic
 Lemay, Albert T., 532 14th av., Paterson
 Levendusky, Daniel E., 52 Market st., Passaic
 LeVine, Israel, 215 Broadway, Paterson
 Levine, Sidney C., 459 Park av., Paterson
 Levinsohn, Sandor A., 656 East 29th st., Paterson
 Levy, Herman, 219 Lexington av., Passaic
 Liana, Stephen M., 48 Market st., Passaic
 Linares, A. Carli, 208 Market st., Paterson
 Lipton, Louis, 67 Passaic av., Passaic
 Lobsenz, Nathan P., 294 Broadway, Paterson
 Lomauro, James R., 145 Lexington av., Passaic
 London, Jules R., 153 Jefferson st., Passaic
 Low, Donald B., 529 Broadway, Paterson
 Lucent, S. Bell, 2 First av., Little Falls
 Luksteid, Casimir J., 326 Park av., Paterson
 MacAlister, Wm. W., 171 Carroll st., Paterson
 MacGregor, Allan W., 379 Ellison st., Paterson
 MacGuffie, Robert N., 657 Main av., Passaic
 Mackler, Meyer E., 575 Broadway, Paterson
 Maclav, Joseph A., 239 Broadway, Paterson
 Maffongelli, Joseph A., 494 River st., Paterson
 Magennis, Bryan C., 270 Broadway, Paterson
 Magnes, Max, 271 Park av., Paterson
 Manly, Thomas E., 390 Park av., Paterson
 Manzione, Frank A., 500 Union av., Paterson
 Maps, Howard L., 53 Passaic av., Passaic
 Marini, Dominick, 40 Henry st., Passaic
 Markel, Albert G., 450 Park av., Paterson
 Markowitz, Louis, 380 Park av., Paterson
 Marsh, Elias J., 400 Van Houten st., Paterson
 Martin, Theodore, 577 Lincoln av., Glen Rock
 Masucci, Alberico, 128 Carroll st., Paterson
 Matthews, Leonard M., 655 Main av., Passaic
 McBride, Andrew F., 30 Church st., Paterson
 McBride, Andrew F., Jr., 655 Broadway, Paterson
 McCamey, Kenneth E., 612 E. 29th st., Paterson
 McCarthy, George L., 506 Union av., Paterson
 McCoy, John C., 292 Broadway, Paterson
 McCue, John B., 912 Lincoln av., Pompton Lakes
 McDede, Frank F., 922 Main st., Paterson
 McDonald, Richard J., 80 Park av., Paterson
 McPherson, Malcolm E., 141 Diam'dBr. av., H'wth'rne
 Meier, William U., 1062 Ringwood av., Haskell
 Meloney, Lester F., 156 Second st., Clifton
 Mendelsohn, David H., 576 Broadway, Paterson
 Meneve, Alfred D., 373 Broadway, Paterson
 Michela, Luigi S., 206 Carroll st., Paterson
 Missonellie, Wm., 404 Lafayette av., Hawthorne
 Mitchell, Charles R., 311 Broadway, Paterson
 Morici, Theodore, 80 Howe av., Passaic
 Morrill, James P., 310 Broadway, Paterson
 Mott, Joseph E., 426 Park av., Paterson
 Murn, Charles J., 48 Smith st., Paterson
 Neer, William, 245 Broadway, Paterson
 Nemirow, Martin, 234 Lexington av., Passaic
 Nesbitt, Elizabeth, No. Jersey Tr'n'gSch'l, Little Falls
 Norval, William A., 419 Main st., Paterson
 Notkin, Meyer, 559 Broadway, Paterson
 Noto, Philip, 158 Washington pl., Passaic
 Nye, Howard H., 174 Carroll st., Paterson
 O'Brian, Dennis M., 154 Lexington av., Passaic
 Okin, Irving, 165 Passaic av., Passaic
 Oppen, Philip, 715 Broadway, Paterson
 Oram, Joseph H., 495 Broadway, Paterson
 Pal, Darbari R., 32 Clark st., Paterson
 Pahnna, Nicholas, 116 17th av., Paterson
 Palmer, Francis R., 220 Lexington av., Passaic

- Park, M. Benjamin, 360 Park av., Paterson
 Patella, Fulvio, 324 Broadway, Paterson
 Perneti, Anthony M., 320 Broadway, Paterson
 Phelps, James E., 203 Park av., Paterson
 Piller, Jacob, 213 Broadway, Paterson
 Plinke, Fritz W., 159 Lexington av., Passaic
 Polizzotti, Joseph L., 193 Park av., Paterson
 Polowe, David, 555 E. 27th st., Paterson
 Prince, Robert A., 567 Broadway, Paterson
 Provisor, Benjamin, 141 Lexington av., Passaic
 Raab, Michael, 226 President st., Passaic
 Radest, Louis J., 347 Broadway, Paterson
 Randazzo, Anton P., 82 Prospect st., Passaic
 Rauschenbach, Paul E., 225 Broadway, Paterson
 Reading, H. Eugene, 535 E. 29th st., Paterson
 Reeves, Ernest, 195 Lexington av., Passaic
 Reilly, Thomas F., 127 Union av., Clifton
 Reiner, David N., 265 Lexington av., Passaic
 Reinhorn, Abraham J., 302 Broadway, Paterson
 Reynolds, Harry C., 657 Main av., Passaic
 Riccobono, Cosmo S., 334 Park av., Paterson
 Richards, Paul S., 1 Main st., Butler
 Rinzler, Harry G., 127 Van Houten av., Passaic
 Ritter, John J., 95 Ward st., Paterson
 Roemer, Jacob, 591 E. 27th st., Paterson
 Romano, Michael J., 468 Union av., Paterson
 Rothman, Theodore, 494 Park av., Paterson
 Roy, Jos. N., 95 17th av., Paterson
 RuBacky, Joseph F. A., 57 Passaic av., Passaic
 Ruocco, William B., 416 River st., Paterson
 Russell, Charles B., 119 Hamilton av., Paterson
 Sabarese, Theodore C., 122 Marsellus pl., Garfield
 Saffron, Morris H., 292 Paulison av., Passaic
 Salzman, Nathan, 714 Broadway, Paterson
 Sanfacon, Thomas A., 340 Park av., Paterson
 Santangelo, Emil L., 349 Broadway, Paterson
 Schafer, Marguerite A., 298D'mondBr. av., H'wth'rne
 Schefrin, Alexander E., 235 Lexington av., Passaic
 Schubert, Roy R., 466 Park av., Paterson
 Schultz, Augustin M., 379 Union av., Paterson
 Schwartz, Jacob, 804 Fairlawn av., Fairlawn
 Schwartz, William, 224 Lexington av., Passaic
 Schwartzberg, Frederick I., 522 Broadway, Paterson
 Seielzo, Nicholas F., 369 Park av., Paterson
 Scribner, Chas. H., Hamb'g Tnpk., R.D.1, Preakness
 Shapiro, Louis G., 375 Broadway, Paterson
 Schectman, Abraham, 261 Main av., Passaic
 Shippee, James N., 648 Ringwood av., Wanaque
 Shulman, Abraham, 528 E. 29th st., Paterson
 Silverman, Irving A., 260 Dayton av., Clifton
 Simkin, Abraham, 247 Broadway, Passaic
 Simon, Julius J., 174 Columbia av., Passaic
 Simon, Morris L., 174 Washington pl., Passaic
 Siveke, John, 106 Lexington av., Passaic
 Slaff, Florence, 16 Grove st., Passaic
 Sloan, Samuel L., 182 Belmont av., Paterson
 Small, Louis, 23 Passaic av., Passaic
 Smith, Carroll D., 320 Broadway, Paterson
 Smith, Elroy W., 39 Circle rd., Passaic
 Smith, Leon A., 655 Main av., Passaic
 Sobel, I. Jerome, 136 Broadway, Passaic
 Spickers, William, 6 Church st., Paterson
 Stark, Jacob, 645 Broadway, Paterson
 Stein, Harold M., 227 W. Broadway, Paterson
 Steinberg, Benjamin L., 543 Main st., Singac
 Stern, Morris H., 709 Main av., Clifton
 Stinson, Richard, 641 E. 18th st., Paterson
 Stokes, James S., 85 Park av., Paterson
 Stolz, Raymond R., 23 Passaic av., Passaic
 Stouter, Francis L., 29 17th av., Paterson
 Sucoff, Moses C., 158 Hamilton av., Passaic
 Sullivan, William M., Jr., 43 Passaic av., Passaic
 Surgent, George W., 168 Clifton av., Clifton
 Sutherland, William W., 400 Broadway, Paterson
 Szymanski, John J., 616 Main av., Passaic
 Taber, Leslie R., 266 Van Houten st., Paterson
 Tellman, Daniel H., 120 Lexington av., Passaic
 Temple, Arthur H., 164 Jefferson st., Passaic
 Terhune, Percy H., 81 Millbrook rd., Hamden, Conn.
 Thomas, Irene O., 350 Lafayette av., Hawthorne
 Thorne, William P., 254 Main st., Butler
 Thron, Leopold E., 586 E. 29th st., Paterson
 Todd, Francis H., 83 Auburn st., Paterson
 Tomkins, William, 105 Fairmount av., Ridgewood
 Tuers, George E., 418 Park av., Paterson
 Tweddel, George K., 239 Broadway, Paterson
 Udinsky, Hyman J., 29 Passaic av., Passaic
 Vanderbeck, James J., 281 Park av., Paterson
 Vanderbeek, Andrew B., 174 Broadway, Paterson
 Vanderbeek, Frank B., 407 Park av., Paterson
 Vander Clock, Cornelius, 23 Passaic av., Passaic
 Van Eerde, Albert, 339 Lafayette av., Hawthorne
 Van Riper, A. Ward, 605 Main av., Passaic
 Van Schott, Gerard J., Jr., 245 Lex'gton av., Passaic
 Van Urk, Frederick T., 422 Lexington av., Clifton
 Van Winkle, John S., 297 Broadway, Paterson
 Vermeulen, Abram, 344 Haledon av., Prospect Park
 Vosburgh, Fred, 61 Passaic av., Passaic
 Vreeland, Ralph J., 266 Van Houten st., Paterson
 Walker, Harold G., Everett av., Wyckoff
 Wallace, Marc J., 165 Lakeview av., Clifton
 Walton, Gordon G., 17 Church st., Paterson
 Warburton, Jack C., 333 Park av., Paterson
 Ward, Albert H., 404 Totowa av., Paterson
 Warren, David E., 154 Broadway, Passaic
 Warren, Earl L., 266 Van Houten st., Paterson
 Warren, Jacob, 308 18th av., Paterson
 Wassing, Hans, 695 Broadway, Paterson
 Weinert, Henry V., 128 Market st., Passaic
 Weintraub, Wm. L., 400 Broadway, Paterson
 Weisman, Stephen L., 566 Broadway, Paterson
 Westerhoff, Peter D., 51 Highland av., Midland Park
 Wethers, William A., 171 Market st., Passaic
 White, Richard E., 303 Crooks av., Paterson
 Williams, Hiram, 230 Lexington av., Passaic
 Winters, Walter M., 288 Broadway, Paterson
 Wishnack, Meyer, 318 Broadway, Paterson
 Wolf, Israel J., 231 East 31st st., Paterson
 Wolfson, Harry, 356 Park av., Paterson
 Wry, Dean A., 234 Dayton av., Clifton
 Yager, J. Allen, 420 Broadway, Paterson
 Yates, John S., 414 Ellison st., Paterson
 Yolken, Harry, 246 E. 31st st., Paterson
 Zalewski, Irene J., 125 Market st., Passaic
 Zuckerman, David E., 345 Broadway, Paterson

Number of Active Members and basis of representation, 367, on March 15, 1941.

Associate Members

Baxt, Sidney J., 544 21st av., Paterson
Blake, Albert, 423 Broadway, Paterson
Charney, William, 647 Broadway, Paterson
Clark, Orlo H., 149 Prospect st., Passaic
Fortuin, Floyd, 423 Broadway, Paterson
Hayman, Irving R., 681 Broadway, Paterson
Krieger, George, 269 Broadway, Passaic
Lawrence, Arthur C., Box 21, Main st., Lincoln Park

Ogden, Michael A., Passaic General Hosp., Passaic
Ross, Peter W., 655 Main av., Passaic
Sheft, Matthew, 100 Hope av., Passaic
Shinefeld, Maurice A., 669 Broadway, Paterson
Siniscal, Arthur A., 149 Prospect st., Passaic
Thompson, Edward C., 373 Park av., Paterson
Visceglia, Frank R., 99 Gregory av., Passaic
Wolf, Erich, 158 Broadway, Passaic

Courtesy Member

Trilling, Leonard J., Paterson

Resigned

Fishbein, Isador L., Miami Beach, Fla.

Transfers

Burrill, Benjamin B., Jr., to Essex County Chapman, Walter A., Jr., from Morris County
Reiner, David N., from Sullivan County, N. Y.

SALEM COUNTY (17)

OFFICERS



WILBUR S. DAVISON
President
Pennsville



JOHN S. DUNN
Secretary-Treasurer
Salem



LEE C. HUMMEL
Reporter
Salem

Society organized May 4, 1880. Meets on the third Friday of each month, September to May, inclusive. Annual Meeting in April. Social Meeting in May.

Active Members

Bramble, Halsey S., Front & Chestnut sts., Elmer
Caggiano, John D., 165 W. Main st., Pennsgrove
Chesler, Maurice, 124 W. Broadway, Salem
Church, Franklin H., 86 W. Broadway, Salem
Davison, C. Spencer, 7 Chestnut st., Salem
Davison, Wilbur S., 13 N. Broadway, Pennsville
Dunn, John S., 75 Market st., Salem
Eisemann, Jerome S., Main st., Alloway
Fleming, Charles L., 42 W. Main st., Pennsgrove
Green, David W., 69 Market st., Salem
Hilliard, William T., 105 Market st., Salem
Hummel, Lee C., 109 W. Broadway, Salem
Jirouch, Edwin A., 18 Ziegler Tract, Pennsgrove

Lipkin, Isadore, 157 W. Main st., Pennsgrove
Lummis, Clarence P., 40 Delaware av., Pennsgrove
Mackes, Claude B., 48 N. Main st., Woodstown
Miller, Lewis H., 37 S. Main st., Woodstown
Miller, William H., 37 S. Main st., Woodstown
Norwood, William D., 164 First st., Carney's Point
Perry, Frank L., 39 East av., Woodstown
Prigger, Edward R., 39 W. Main st., Pennsgrove
Silverman, R. Louis, 3 Franklin st., Pennsgrove
Suter, Harry F., 49 W. Main st., Pennsgrove
Thomas, Claude W., 28 East av., Woodstown
Weigel, Charles F. B., 328 E. Broadway, Salem
Zappala, John, 47 W. Main st., Pennsgrove

Number of Active Members and basis of representation, 26, on March 15, 1941.

Honorary Member

James, William H., Pennsville

Resigned

James, William H., Pennsville

SOMERSET COUNTY (18)**OFFICERS**

J. HOWARD COOPER
President
East Millstone



DONALD O. HAMBLIN
Secretary
Bound Brook



ALBERT W. PIGOTT
Treasurer
Skillman



SIDNEY S. EDELBERG
Reporter
Bound Brook

Society organized May 21, 1816. Meets on second Thursday evening of each month except July, August and September. Annual Meeting in June. Dinner Meeting in October.

Active Members

Adams, Rayford K., Lakeside Lodge, Skillman
Albrecht, William J., 25 N. Bridge st., Somerville
Allegrante, Anthony J., W'sh'gt'nVal.rd.,Martinsville
Ambrose, Robert R., 124 Hamilton st., Bound Brook
Barbour, George E., 118 W. High st., Somerville
Bendix, Gerhard M., 56 E. Somerset st., Raritan
Blank, Samuel, N. J. State Village, Skillman
Borow, Benjamin, 507 Church st., Bound Brook
Borow, Henry 507 Church st., Bound Brook
Borow, Louis S., 507 Church st., Bound Brook
Borow, Maurice, 507 Church st., Bound Brook
Brittain, Elmore G., 4 E. High st., Bound Brook
Coolcy, Justus H., 3 W. Union av., Bound Brook
Cooper, J. Howard, East Millstone
Craig, Henry A., 315 William st., Somerville
Crawford, John W., Main st., Bedminster
Day, Hayward F., 37 Craig pl., N. Plainfield
Douglas, William C., 15 Olcott av., Bernardsville
Edelberg, Sidney S., 403 E. High st., Bound Brook
Ely, Lancelot, 128 W. High st., Somerville
Falcone, Nicholas A., 68 Watchung av., N. Plainfield
Field, Frank L., Far Hills
Flint, Edgar T., 44 E. Somerset st., Raritan
Flynn, Thomas H., 41 W. High st., Somerville
Fritts, Lewis C., West End av., Somerville
Galgoczy, Julius, Manville
Gray, W. Burritt, 121 Somerset st., N. Plainfield
Greenberg, George A., 195 W. High st., Somerville
Guertin, Diomedes, N. J. State Village, Skillman
Hamblin, Donald O., Calco Chemical Co., Bound Br'k
Heaton, Stuart C., Calco Chemical Co., Bound Br'k

Hegeman, Runkle F., 161 W. High st., Somerville
Hird, Emerson F., 118 E. Maple av., Bound Brook
Hochheimer, Arthur, 211 Hamilton st., Bound Br'k
Husted, Samuel H., Neshanic Station
Kay, Clarence R., Main st., Peapack
Klompus, Irving, 403 E. High st., Bound Brook
Knight, Augustus S., Larger Cross Roads, Peapack
Lawton, A. Anderson, 15 N. Bridge st., Somerville
Levy, Abram, 1127 W. 7th st., Plainfield
Loeb, William A., Veterans' Adm., Lyons
Lovejoy, James L., 224 Somerset st., Bound Brook
Mangelsdorff, Arthur F., Calco Chem. Co., B'd Brook
McConaughy, Francis, 1 E. High st., Somerville
Morris, Nathan, 40 Grove st., North Plainfield
Pearson, Theodore A., White House
Pigott, Albert W., N. J. State Village, Skillman
Pitman, Mason W. H., 17 W. Cliff st., Somerville
Pogoloff, Samuel H., 68 N. 1st av., Manville
Reale, Frank P., Brook's Blvd., Manville
Reale, Nicholas P., Brook's Blvd., Manville
Renner, Clara C., N. J. State Village, Skillman
Robinson, John T., 598 Watchung av., Bound Br'k
Rossi, Gene, 79 Talmage av., Bound Brook
Russo, Dominick T., 51 E. Somerset st., Raritan
Schram, William S., N. J. State Village, Skillman
Smalley, Mahlon C., Gladstone
Spaldo, John L., N. J. State Village, Skillman
Thornton, P. John S., Veterans' Administration, Lyons
Wallach, Bernard, 74 Watchung av., No. Plainfield
Wild, Frederick A., 111 E. High st., Bound Brook
Young, James L., 68 Mountain av., Somerville

Number of Active Members and basis of representation, 62, on March 15, 1941.

Transfers

Horland, Ephraim, to Essex County

Kibbe, Milton H., to Union County

SUSSEX COUNTY (19)

OFFICERS



JESSE McCALL
President
Newton



VICTOR E. BURN
Secretary
Newton



EDWARD K. HAWKE
Treasurer
Newton



FRANK H. LUSHEAR
Reporter
Branchville

Society organized August 22, 1829. Meets at call of President. Annual Meeting on second Tuesday in May.

Active Members

Aitken, Herbert M., Ogdensburg
Bergmann, Ewald H., 44 Bank st., Sussex
Braun, David C., 216 Spring st., Newton
Burn, Victor E., 27 Trinity st., Newton
Coleman, Joseph G., Hamburg
Drake, Leo B., 47 Main st., Franklin
Eddy, Lester R., 40 Bank st., Sussex
Groeschel, August H., 31 Bank st., Sussex
Hawke, Edw. K., 113 Main st., Newton
Johnson, George F., Branchville
Kirschner, Martin L., Vernon
Landes, Edwin W., Stillwater
Longnecker, John E., Jr., Sparta

Vermes, Leslie, 172 Main st., Franklin

Loux, Henry A., 40 Main st., Sussex
Lushear, Frank H., Branchville
McCall, Jesse, 9 Linwood av., Newton
McVeigh, Charles J. D., Netcong
Morrison, Frederick H., 61 High st., Newton
Pellett, Thomas L., Hamburg
Roy, Bert W., 25 Hamburg av., Sussex
Schmidt, Clifford M., 81 Main st., Newton
Scott, Frederick J., 1 Oak st., Franklin
Smith, Warren H., 91 Main st., Newton
Spencer, James H., Jr., 23 Hospital rd., Franklin
Spurgeon, Chilton E., 19 Church st., Newton
Spurgeon, Dorsett L., 19 Church st., Newton

Number of Active Members and basis of representation. 27, on March 15, 1941.

UNION COUNTY (20)

OFFICERS



GEORGE KNAUER
President
Elizabeth



FREDERIC W. LATHROP
Secretary
Plainfield



GEORGE T. BANKER
Treasurer
Elizabeth



CEDRIC C. CARPENTER
Reporter
Summit

Society organized June 7, 1869. Meets on second Wednesday of September, November, January, March, April, and May. Annual Meeting in April.

Active Members

- Abel, Henri E., 339 Union av., Elizabeth
 Abramson, Solomon, 1587 Irving st., Rahway
 Ackerman, Arthur F., 129 Summit av., Summit
 Anson, Leon J., 314 Center st., Garwood
 Armstrong, Lorrimer B., 121 S. Euclid av., Westfield
 Arthur, Frances H., 138 Westfield av., Elizabeth
 Austin, Thomas R., 19 Holly st., Cranford
 Babbitt, Hugh M., Jr., 950 Park av., Plainfield
 Baker, Raymond D., 52 De Forest av., Summit
 Banker, George T., 1145 E. Jersey st., Elizabeth
 Barberio, A. Albert, 1337 Orange av., Union
 Baron, Leo E., 727 N. Wood av., Linden
 Baruch, Rudolf J., 202 Stiles st., Elizabeth
 Beisler, Lawrence G., 1528 N. Broad st., Hillside
 Bensley, Maynard G., 129 Summit av., Summit
 Berenson, Samuel J., 1012 E. Jersey st., Elizabeth
 Berman, Leonard M., 155 Summit av., Summit
 Berman, Sol., 351 Rahway av., Elizabeth
 Bernstein, Benedict J., 434 E. Front st., Plainfield
 Berry, C. Hartley, 129 Summit av., Summit
 Birrell, Russell G., 554 Westminster av., Elizabeth
 Bishop, Carl, 831 Madison av., Plainfield
 Black, Max S., 1320 St. George av., Linden
 Blair, Thomas D., 414 Park av., Plainfield
 Blatt, David, 960 Madison av., Elizabeth
 Bloch, Harry, 613 N. Broad st., Elizabeth
 Blumberg, Jack, 504 Westminster av., Elizabeth
 Blythe, Rowland P., 30 Springfield av., Cranford
 Bolanowski, Kasimir J., 145 Marshall st., Elizabeth
 Booth, Walter S., 318 Grier av., Elizabeth
 Boozan, Wm. E., 1139 E. Jersey st., Elizabeth
 Bourns, Edward G., 203 S. Euclid av., Westfield
 Bowles, Harry H., 36 Woodland av., Summit
 Boyd, Robert P., 120 Martine av., S., Fanwood
 Boyer, Paul K., 129 Summit av., Summit
 Boyes, James G., 1326 Chetwynd av., Plainfield
 Breslow, Alexander E., 930 Pierpont st., Rahway
 Brethwaite, Samuel H., Jr., 129 Summit av., Summit
 Brokaw, Chris. A., 1405 North av., Elizabeth
 Brown, L. Greeley, 173 Madison av., Elizabeth
 Brown, William H., 29 Third st., Elizabeth
 Burritt, Norman W., 30 Beechwood rd., Summit
 Butenas, Joseph J., 300 First av., Elizabeth
 Callahan, Edward J., 124 St. Paul st., Westfield
 Canright, Cyril M., 34 Springfield av., Cranford
 Cantini, Raphael S., 147 E. 7th st., Plainfield
 Card, Charles F., 144 W. Milton av., Rahway
 Carlisle, J. Mallory, 550 Hillcrest av., Westfield
 Carman, John H., 602 Crescent av., Plainfield
 Carpenter, Cedric C., 129 Summit av., Summit
 Carsley, Sidney H., 19 Holly st., Cranford
 Casilli, Arturo R., 618 Newark av., Elizabeth
 Chaiken, Louis H., 102 E. Jersey st., Elizabeth
 Chapman, Otis P., 125 Broad st., Elizabeth
 Childers, Robert J., 604 Park av., Plainfield
 Chodosh, Maurice A., 606 Roosevelt, Carteret
 Cohen, Harry X., 1 Garden drive, Roselle
 Cole, Walter H., Jr., 1060 E. Jersey st., Elizabeth
 Comunale, Anthony R., 1709 Irving st., Rahway
 Conway, James V., 428 Elmora av., Elizabeth
 Coplin, George J., 510 E. Jersey st., Elizabeth
 Corbusier, Harold D., 612 Park av., Plainfield
 Crabtree, Loren H., 142 Bellevue st., Elizabeth
 Crane, Norman T., 147 E. Seventh st., Plainfield
 Cronin, Francis J., 730 South st., Elizabeth
 Currie, Norman W., 508 Central av., Plainfield
 Dalberg, Walter, 500 Cherry st., Elizabeth
 Davidson, E. Norwell, 192 Elm st., Linden
 Davidson, Maurice M., 128 Grant av. E., Roselle Pk
 Davis, F. Cleveland, 129 Summit av., Summit
 Davis, James T., 1169 Elizabeth av., Elizabeth
 Davis, Stanton H., 212 E. 7th st., Plainfield
 Day, Willis B., 407 E. 7th st., Plainfield
 DeCesare, Ferdinand J., 500 Walnut st., Roselle Pk
 Decker, Charles T., 275 Orchard st., Westfield
 Demarest, Gerald B., 531 E. Broad st., Westville
 Deutsch, Nathan S., 300 W. 7th st., Plainfield
 Diamond, J. George, 512 W. Front st., Plainfield
 Doggett, E. Hugh, 916 Park av., Plainfield
 Dolsky, Irving, 509 N. Wood av., Linden
 Drury, Alfred J., 268 E. Third av., Roselle
 duBuse, L. C. Victor, 399 Westfield av., Elizabeth
 Dunn, H. Irving, 610 Salem av., Elizabeth
 Durrah, Fred F., 310 Plainfield av., Plainfield
 Dwoyer, Leon C., 420 N. Wood av., Linden
 Eason, Samuel W., 48 De Forest av., Summit
 Edgar, Malcolm S., 129 Summit av., Summit
 Ehrlich, Max, 379 Elmora av., Elizabeth
 Esty, Geoffrey W., 629 E. Broad st., Westfield
 Feleppa, Edward E., 618 Springfield av., Summit
 Fiedler, Michael J., 247 Crawford ter., Union
 Fitch, Thomas S. P., 916 Park av., Plainfield
 Fort, William B., 147 E. 7th st., Plainfield
 Fourcher, Kenneth R., Standard Oil Co., Linden

- Foster, Frank L., 320 Springfield av., Cranford
Franklin, Joseph E., 127 Westfield av., Elizabeth
Franklin, Lewis J., 149 Jean ter., Union
Frohwein, Ida H., 125 Morristown rd., Elizabeth
Gadomski, Casimir F., 331 So. Broad st., Elizabeth
Galloway, George E., 163 W. Milton av., Rahway
Gannon, Joseph M., 1137 Park av., Plainfield
Geary, Paul, 909 Park av., Plainfield
Gelber, Isaac, 2052 Morris av., Union
Gerendasy, Julius, 956 E. Jersey st., Elizabeth
Gibb, Alice S., 339 Union av., Elizabeth
Giglio, Alphonsus S. V., 626 Elizabeth av., Elizabeth
Gilpin, Fletcher, 118 North av. W., Cranford
Gittelman, Morton, 426 Westminster av., Elizabeth
Glaser, Emanuel, 260 Linden av., Elizabeth
Glass, Benjamin E., 609 Watchung av., Plainfield
Glassner, Frank, 308 Chestnut st., Roselle
Glasston, Hyman M., 628 N. Wood av., Linden
Golden, William M., 236 W. Milton av., Rahway
Goldfield, Harold H., 225 E. Jersey st., Elizabeth
Goldmacher, Herman B., 113 Elmora av., Elizabeth
Goldstein, Herman H., 318 W. Jersey st., Elizabeth
Gonczy, Edw. J., 538 Jersey av., Elizabeth
Grant, William E., 1370 Morris av., Union
Greenberg, Max, 29 W. Henry st., Linden
Gregory, Roy A., 726 Watchung av., Plainfield
Griesemer, Z. Lawrence, 1145 E. Jersey st., Elizabeth
Griswold, Merton L., Jr., 947 Park av., Plainfield
Guidi, Guido M., 212 Christine st., Elizabeth
Hackett, Edw. J., 597 Westfield av., Westfield
Hall, Winthrop H., 400 Elm st., Westfield
Hallock, Wilton J., 650 Springfield av., Summit
Hanrahan, James M., 678 N. Broad st., Elizabeth
Hansen, Harry, 916 Park av., Plainfield
Hanson, Carl G., 38 Springfield av., Cranford
Haseltine, Sherwin L., 125 Broad st., Elizabeth
Herrington, Lee R., 605 E. Broad st., Westfield
Hill, Clarence T., 116 E. Hazelwood av., Rahway
Hipple, Percy L., 230 Walnut st., Roselle
Hnat, Frederick, 624 Newark av., Elizabeth
Hoffman, Charles A., 302 E. 7th st., Plainfield
Holland, Reuben J., 1026 Chandler av., Linden
Holmes, Grace A., 1077 E. Jersey st., Elizabeth
Holt, Evelyn, 261 Springfield av., Summit
Horoschak, Anne, 974 Park av., Plainfield
Horre, George W. H., 203 W. Jersey st., Elizabeth
Hubbard, Harry H. V., 121 E. 7th st., Plainfield
Hughes, Frederic J., 706 Park av., Plainfield
Humphrey, Hubert G., 430 Downer st., Westfield
Hunt, Thomas F., 528 Monore av., Elizabeth
Hutton, Frederick T., 915 Park av., Plainfield
Imbleau, Joseph E. L., 2106 Morris av., Unionville
Jacobs, Alan L., 1243 Stuyvesant av., Unionville
Johnson, Harold F., 734 Park av., Plainfield
Jones, Herbert E., 47 Elm st., Elizabeth
Jones, Lewis H., 139 E. Grant av., Roselle Park
Kapp, Carl G., 440 Westminster av., Elizabeth
Karshmer, Ernest E., 927 S. Wood av., Linden
Keeney, Cadwell B., 137 Summit av., Summit
Keil, Sigmund S., 1182 St. George av. E., Linden
Kemper, Harry T., 224 Monmouth rd., Elizabeth
Kibbe, Milton H., 916 Park av., Plainfield
Klein, Henry L., Merck and Co., Rahway
Knauer, George, 930 Elizabeth av., Elizabeth
Konzelman, Henry J., 65 King st., Hillside
Kramer, Douglas W., 1019 Park av., Plainfield
Krans, DeHart, 920 Park av., Plainfield
Krans, Edward S., 920 Park av., Plainfield
Kreutz, Paul J., 363 Union av., Elizabeth
Kuchlewski, Edward J., 224 E. Jersey st., Elizabeth
Kushner, Alexander, 208 W. Milton av., Rahway
Labow, Joseph J., 757 N. Broad st., Elizabeth
Ladas, George, 305 Cherry st., Elizabeth
Laird, George S., 127 Central av., Westfield
Lance, Elton W., 125 W. Milton av., Rahway
Larrabee, Callie H., 24 Hobart av., Summit
Lathrop, Frederic W., 909 Park av., Plainfield
Laurie, Andrew L., 664 Newark av., Elizabeth
Lawrence, William H., 129 Summit av., Summit
Leggett, Lindley H., Jr., 330 E. Broad st., Westfield
Leggett, Thomas H., Jr., 706 Park av., Plainfield
Lepree, Joseph A., 371 Morris av., Elizabeth
Lerman, Irving, 1024 E. Jersey st., Elizabeth
Lewis, Albert, 41 Retford av., Cranford
Lieberman, David P., 597 Westminster av., Elizabeth
Lieberman, Milton L., 101 Pershing av., Roselle Pk
Lilien, Milton M., 152 Clark st., Hillside
Linke, James J. P., 245 E. Front st., Plainfield
Livengood, Horace R., 587 Westminster av., Elizabeth
Lull, Gabriel J., 266 Morris av., Springfield
Lowell, Milton E., 434 Summit av., Westfield
Lowenstein, Ernest C., 1492 Main st., Rahway
Lufburrow, Chas. B., 441 W. Front st., Plainfield
Lyerly, James M., 121 E. 7th st., Plainfield
Lynch, Edward T., 748 Livingston rd., Elizabeth
MacBrayer, Reuben A., Ciba Co., Laf'ette Pk., Sum't
Maggio, Ross J., 206 Park av., Westfield
Malatesta, Chas. S., 1203 Martine av., Plainfield
Marone, Carmine R., 648 1st av., Elizabeth
Maroney, James H., 129 Summit av., Summit
Marts, George H., 956 Park av., Plainfield
Mastroianni, Frank M., 901 Colonial av., Union
McAlpine, Paul, 129 Summit av., Summit
McCallion, Wm. H., 722 Westminster av., Elizabeth
McGeary, John A., 610 Salem av., Elizabeth
McGinn, Wm. J., 1913 Westfield av., Scotch Plains
Meeker, John L., 6 De Barry pl., Summit
Meineke, William C., Jr., 818 Chestnut st., Roselle
Merlo, Francis A., 210 Murray st., Elizabeth
Merlo, Francis V., 39 3rd st., Elizabeth
Miller, Robt. M., 382 Springfield av., Summit
Mills, Stephen D., 132 S. Euclid av., Westfield
Minnella, Thos. J., 132 Morris av., Summit
*Moister, Roger W., 30 Beechwood rd., Summit
Montfort, Robert J., 1051 E. Jersey st., Elizabeth
Morris, Thomas M., 505 Park av., Plainfield
Morris, Watson B., 193 Morris av., Springfield
Munger, Ray T., 727 Watchung av., Plainfield
Murphy, Albert T., 1108 Anna st., Elizabeth
Murphy, Herschel S., 320 Chestnut st., Roselle
Murray, Norman L., 129 Summit av., Summit
Naidorff, Saul A., 404 W. 7th st., Plainfield
Nittoli, Rocco M., 660 E. Jersey st., Elizabeth
Novello, Joseph A., 641 Second av., Elizabeth
Nussbaum, Joseph, 321 Elmora av., Elizabeth
Obester, Gabriel E., 640 N. Broad st., Elizabeth
O'Brien, Edwin J., Jr., 507 Park av., Plainfield
Oderr, Charles, 116 S. Euclid av., Westfield
Orton, Foster, 196 Elm av., Rahway
Orton, George L., 196 Elm av., Rahway
Osher, Morris M., 157 North av., Fanwood
Owen, Philip, 1273 Stuyvesant av., Union
Paulson, Arch M., 160 E. 7th st., Plainfield
Pearl, Sydney S., 545 Rahway av., Elizabeth
Peters, Richard C., 963 Park av., Plainfield
Phelan, Walter F., 124 Chilton st., Elizabeth
Polshuck, Ruben, 100 Hollywood av., Hillside
Polk, Charles C., 114 E. 7th av., Roselle
Pollack, Louis, 1008 E. Jersey st., Elizabeth
Prout, Thomas P., 19 Prospect st., Summit
Read, Jessie D., 519 Lenox av., Westfield
Reich, Jerome J., 1410 Maple av., Hillside
Reiner, Jacob, 811 N. Broad st., Elizabeth
Reiter, Walter A., 50 DeForest av., Summit
Relyea, George M., 129 Summit av., Summit
Ripps, Maurice L., 410 Elmora av., Elizabeth
Robertson, Grace M., 650 W. 7th st., Plainfield
Rose, Abraham, 326 So. Broad st., Elizabeth
Rosenstein, Saivel L., 2120 Springfield av., Vauxhall
Rubin, David, 200 E. Jersey st., Elizabeth

Runnells, John E., Bonnie Burn Sana., Scotch Plains
 Sadoff, Joseph, 116 Elmora av., Elizabeth
 Salvati, Leo H., 275 Orchard st., Westfield
 Samuels, S. Lawrence, 219 W. 7th st., Plainfield
 Satulsky, Emanuel M., 652 Park av., Elizabeth
 Schenk, Joseph R., 1177 Park av., Plainfield
 Schiller, Edwin, 449 Westminster av., Elizabeth
 Schiller, Rosa O., 449 Westminster av., Elizabeth
 Schilling, Anthony B., 727 Jefferson av., Elizabeth
 Schlein, David, 812 No. Wood av., Linden
 Schlichter, Chas. H., 556 N. Broad st., Elizabeth
 Schwartz, Samuel H., 1044 Park av., Plainfield
 Schweizer, Roman G., 36 Summit rd., Elizabeth
 Seeler, Albert O., 33A Garden drive, Roselle
 Sell, Frederick W., 167 W. Emerson av., Rahway
 Senerchia, Fred F., Jr., 604 Westminster av., Eliza.
 Seybold, Arthur D., 1080 Rahway road, Plainfield
 Seymour, George A., 253 Orchard st., Elizabeth
 Shangle, Milton A., 34 Prince st., Elizabeth
 Sherman, Samuel H., 81 Elmora av., Elizabeth
 Shirrefs, Russell A., 348 Elmora av., Elizabeth
 Sims, Richard V., Jr., 21 Morris av., Summit
 Singer, Bella, 406 Elmora av., Elizabeth
 Sly, John L., 382 Springfield av., Summit
 Spirito, Michael W., 1071 Elizabeth av., Elizabeth
 Spivack, David, 376 Elmora av., Elizabeth
 Stanton, Nathaniel B., 734 Park av., Plainfield
 Staub, E. Milton, 531 E. Broad st., Westfield
 Steele, Stephen, 10 West Gibbons st., Linden
 Stein, Emil, 607 Park av., Elizabeth
 Stein, George H., 406 Elmora av., Elizabeth
 Stein, Isadore, 817 N. Broad st., Elizabeth
 Stein, Martin H., 60 Elmora av., Elizabeth
 Steinberg, Werner, 35 Gesner st., Linden
 Stephenson, Gordon A., 145 Summit av., Summit
 Steuart, David F. R., 11 De Barry pl., Summit
 Stevenson, G. M., 129 Summit av., Summit
 Stillwell, Harry C., 51 W. Milton av., Rahway
 Strauss, Clifton J., 960 Springf'd av., New Providence
 Strelinger, Alexander, 650 N. Broad st., Elizabeth
 Strom, Abraham, 410 W. 7th st., Plainfield
 Stuart, J. Earle, 552 E. 2nd st., Plainfield
 Stybel, Joseph, 806 W. Front st., Plainfield
 Suffness, Gustave, 1081 E. Jersey st., Elizabeth
 Taranto, Michael, 635 N. Wood av., Linden
 Tator, Arthur E., 57 DeForest av., Summit
 Terrell, Edward E., 16 Alden st., Cranford
 Tidaback, John D., 382 Springfield av., Summit
 Tomlinson, Rolland D., 445 E. Broad st., Westfield
 Townsend, Leslie M., 420 Chestnut st., Roselle Park
 Triarsi, Anthony J., 702 3rd av., Elizabeth
 Tyndall, Alice E., 263 Walnut st., Westfield
 Tyndall, Martha W., 263 Walnut st., Westfield
 Vinciguerra, Michael, 604 Westminster av., Elizabeth
 Vitale, Dominic V., 681 Newark av., Elizabeth
 Vitolo, Ralph E., 934 Orchard ter., Linden
 Vogel, H. Austin, 1060 E. Jersey st., Elizabeth
 Wacker, William F., 1224 Salem av., Hillside
 Wade, Simon F., 555 Newark av., Elizabeth
 Wagner, Richard, 612 N. Broad st., Elizabeth
 Walsh, Ronald J., 118 E. 5th av., Roselle
 Walsh, Thomas J., 335 S. Broad st., Elizabeth
 Ward, Leo J., 137 W. Jersey st., Elizabeth
 Webb, Eleanor A., 887 Springfield av., New Providence
 Wegryn, Louis S., 257 Elizabeth av., Elizabeth
 Weigel, Edgar W., 970 Park av., Elizabeth
 Weigel, Elmer P., 727 Watchung av., Plainfield
 Weissman, Meyer T., 947 E. Jersey st., Elizabeth
 Weltchek, Herbert, 240 Lincoln av., Elizabeth
 Western, Frederic B., 1227 Morris av., Townley
 Whinery, Joseph F., 53 Templar way, Summit
 Whitken, Albert I., 1056 North av., Elizabeth
 Williams, Frank A., 324 W. Jersey st., Elizabeth
 Williams, Leonard D., 915 Park av., Plainfield
 Wolff, Jerome M., 1414 Martine av., Plainfield
 Wolgin, Philip L., 445 Elmora av., Elizabeth
 Woody, McIver, 454 Union av., Elizabeth
 Wuester, William O., 238 Exter way, Hillside
 Yagol, Benjamin, Bonnie Burn Sana., Scotch Plains
 Yellin, Charles H., 525 E. Second av., Roselle
 Yood, Raphael, 401 Grant av., Plainfield
 Young, Franklin C., 120 Summit av., Summit
 Yuckman, Robert O., 224 W. Jersey st., Elizabeth
 Zeitlin, Herman H., 943 N. Wood av., Linden
 Zingales, Joseph A., 101 Holly st., Cranford

Number of Active Members and basis of representation, 329, on March 15, 1941.

Honorary Members

Carman, John H., Plainfield

Montford, Robert J., Elizabeth

Resigned

Goldgraben, Seymour, New York City

McClintock, Elsie, Hillside

Mohr, Frank L., Union

Transfers

Barberio, A. Arthur, from Kings County, N. Y.

Kibbe, Milton H., from Somerset County

Knepper, Orcena F., to Miami County, Kansas

Kralik, Joseph J., to Essex County

McAlpine, Paul, from New York County

Tomlinson, Rolland D., from New York County

WARREN COUNTY (21)

OFFICERS



RALPH M. BUCHANAN
President
Phillipsburg



NEUMANN C. MARLETT
Secretary
Belvidere



GEORGE W. CUMMINS
Treasurer
Belvidere



HARRY B. BOSSARD
Reporter
Phillipsburg

Society organized February 15, 1826. Meets on third Tuesday of January, April, July and October, the last being the Annual Meeting.

Active Members

Baldauf, Herman, Jr., Front st., Belvidere
Boquist, Walter A., 380 Hudson st., Phillipsburg
Bossard, Harry B., R. D. No. 2, Phillipsburg
Bostwick, Wallace R., Main st., Blairstown
Brasfield, Edgar N., 218 Chambers st., Phillipsburg
Buchanan, Ralph M., 8 Market st., Phillipsburg
Cummins, George W., 202 Mansfield st., Belvidere
Domine, Anthony Z., Blairstown
Drake, Paul F., 85 Summit av., Phillipsburg
Dresel, Irmgard, Far Hills
Hackett, Leon W., 173 Belvidere av., Washington
Humbert, Joseph C., Jr., Stewartsville
Jackson, Dominick P. D., 420 Front st., Belvidere
Varney, William H., 122 Belvidere av., Washington

Kassow, Philip B., North Blvd., Alpha
Kimmel, Seymour S., Oxford
Krausz, Emery, 577 S. Main st., Phillipsburg
Lemmon, Junius M., 28 W. Wh'ngton av., Wash'gt'n
Lyon, Charles H., So. Main st., Phillipsburg
Marlett, Neumann C., 230 Greenwich st., Belvidere
McMurtrie, William A., 20 Franklin st., Morristown
Patton, Paul B., Phillipsburg
Potter, Charles W., Belvidere av., Washington
Shimer, Floyd A., 88 Lewis st., Phillipsburg
Smith, J. Meredith, 212 Grand av., Hackettstown
Spillane, Timothy H., 379 S. Main st., Phillipsburg
Vail, William P., 522 Magnolia av., Orlando, Fla.
Vail, William P., 522 Magnolia av., Orlando, Fla.

Number of Active Members and basis of representation, 27, on March 15, 1941.

NUMBER OF MEMBERS ON THE OFFICIAL LIST, MARCH 15, 1941

	Active Members	Associate Members
Atlantic	107	
Bergen	280	
Burlington	60	
Camden	186	
Cape May	25	
Cumberland	62	
Essex	1005	71
Gloucester	51	
Hudson	453	
Hunterdon	25	
Mercer	242	18
Middlesex	153	23
Monmouth	136	1
Morris	116	
Ocean	29	3
Passaic	367	16

Salem	26	
Somerset	62	
Sussex	27	
Union	329	
Warren	27	
Total	3768	132

SUMMARY

	March 15, 1940	March 15, 1941
Active	3655	3768
Associate	142	132
Total	3797	3900
Increase in Number of Members		103
Deaths of Members During the Year ..		32



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[illegible]



